

II. Eligibility, Covered Services, Enrollment



A. Eligibility /Enrollment Overview

In order to understand this section of the Provider Manual more fully, it may be helpful to clarify the following definitions:

"Eligible individuals" mean those individuals who are eligible for enrollment in the Dallas Area NorthSTAR behavioral healthcare system because they meet federal or state criteria for the use of federal/state funds. Eligible individuals may receive some or all services on the Service Matrix.

"Covered services" means the array of services identified in the State's Service Matrix.

"Benefits" mean the specific type and number of services a specific eligible individual may receive through the NorthSTAR program, as a result of specific eligibility factors, state/federal policies, or funding priorities. Some eligible individuals are entitled to all medically necessary covered services; others may only have benefits for a limited number of services.

B. Types of Eligible Individuals

1. Medicaid Eligible Individuals

Individuals in the Medicaid groups listed below who reside in any part of the service area are eligible for covered services:

- Temporary Assistance to Needy Families (TANF) Adults
- Temporary Assistance to Needy Families (TANF) Children
- Pregnant Women – Medical Assistance Only (MAO) – Pregnant women whose family income is below 185% of the Federal Poverty Limit
- Newborns –children under age one born to MAO Mothers
- Expansion Children and Federal Mandate Children (MAO)
- Disabled and/or Blind Individuals with or without Medicare (or non-institutional SSI)
- State or Federal Adoption Subsidy

If the individuals listed above do not choose to enroll in *ValueOptions*, the State will enroll them.

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2. Non- Medicaid Eligible Individuals

Individuals who are not eligible for Medicaid under Section 1 above may receive covered services if such individuals reside in the service area and meet the criteria described below.

Individuals who meet the DSHS mental health priority population definition, as described in the table on the following page entitled, "Mental Health Priority Population Definitions - Children and Adolescents".

- Any youth who has a substance abuse or chemical dependency diagnosis is eligible for all covered services as clinically indicated.
- Adults with a chemical dependency diagnosis are eligible for all covered services as clinically indicated.
- Adults with a substance abuse diagnosis are eligible for outpatient treatment programs only.
- Pregnant women, women with dependent children, and parents of children in foster care with substance abuse or chemical dependency diagnoses are eligible for all Covered Services as clinically indicated.
- Persons with HIV with substance abuse or chemical dependency diagnoses are eligible for all covered services as clinically indicated.
- Persons with substance abuse or dependency diagnoses who use needles to take drugs are eligible for all covered services as clinically indicated.
- Individuals who qualify or are enrolled in CHIP (Children's Health Insurance Program), but have exhausted the benefit the individual is seeking.
- Are financially qualified for the program by meeting the criteria of 200% of poverty or below

The following pages outline the specific eligibility criteria for non-Medicaid individuals:

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Mental Health Priority Population Definitions - Children and Adolescents

Population	If the person is...	And has a...	And...	Then the person is...
Children	Under the age of 4 years	DSM IV Axis I diagnosis other than or in addition to: <ul style="list-style-type: none"> • Substance abuse • Mental Retardation • Autism or * Pervasive Developmental Disorder		Initially eligible for DSHS state-funded MH services.
Children	Between the ages of 4 through 6 years	DSM-IV Axis I diagnosis other than or in addition to: <ul style="list-style-type: none"> • Substance abuse • Mental Retardation • Autism or * Pervasive Developmental Disorder	Is at risk of removal from preferred child care environment	Initially eligible for DSHS state-funded MH services.
Children & Adolescents	Under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: <ul style="list-style-type: none"> • Substance abuse • Mental Retardation • Autism or * Pervasive Developmental Disorder	Has been determined by the school system to have a serious emotional disturbance	Initially eligible for DSHS state-funded MH services.
Children & Adolescents	Under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: <ul style="list-style-type: none"> • Substance abuse • Mental Retardation • Autism or * Pervasive Developmental Disorder	Is at risk of disruption of the preferred living situation due to psychiatric symptoms	Initially eligible for DSHS state-funded MH services.
Children & Adolescents	Under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: <ul style="list-style-type: none"> • Substance abuse • Mental Retardation • Autism or * Pervasive Developmental Disorder	Has a functional impairment (GAF of 50 or less -- current)	Initially eligible for DSHS state-funded MH services.

Reference: *DSM-IV Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

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Mental Health Priority Population Definitions - Adults

Initial Criteria

Population	If the person is...	And has a...	And...	And...	Then the person is...
Adults	18 or older 18 or older	Diagnosis of: <ul style="list-style-type: none"> • Schizophrenia • Bipolar Disorder *Major Depression Served in children's service and meet children's priority definition prior to turning 18			Initially eligible for DSHS state-funded MH services for one year. Initially eligible for DSHS state-funded MH services for one year.

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Priority Population DSM-IV Codes

Any of the following:

Mood Disorders:

296.00	296.01	296.02	296.03	296.04	296.05	296.06
296.40	296.41	293.42	296.43	296.44	296.45	296.46
296.50	296.51	296.52	296.53	296.54	296.55	296.56
296.60	296.61	296.62	296.63	296.64	296.65	296.66
296.7	296.80	296.89				

296.20	296.21	296.22	296.23	296.24	296.25	296.26
296.30	296.31	296.32	296.33	296.34	296.35	296.36

Schizophrenia:

295.10	295.20	295.30	295.40	295.60	295.70	295.90
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Single Diagnosis of:

Substance Abuse:

291.0	291.1	291.2	291.3	291.5	291.8	291.9
292.0	292.11	292.12	292.81	292.82	292.83	292.84
292.89	292.9	303.00	303.90	304.00	304.10	304.20
304.30	304.40	304.50	304.60	304.80	304.90	305.00
305.10	305.20	305.30	305.40	305.50	305.60	305.70
305.90						

Please note that Non-Medicaid individuals may be required to pay a co-payment for services on a sliding fee schedule based on their income and ability to pay. We will discuss our policy on co-payments in Section III of this Manual.

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C. Covered Mental Health Benefits

All services identified on the following Service Matrix are covered services in the NorthSTAR system. As we have noted above, however, **not all consumers may be eligible for all covered services under this program.** (When it is determined that a consumer needs a covered service for which she/he is eligible but which is not currently available through the NorthSTAR Program, the Provider should contact the *ValueOptions* ACCESS LINE for assistance in obtaining the needed service). The covered services under the NorthSTAR Program for Mental Health include benefits listed on the following page:

Please note: in order for a consumer to receive benefits under this plan, the consumer must meet medical necessity criteria. Also note that, with the exception of three outpatient pass through units (annually per member effective September 1), all services must be preauthorized.

See Section IV (Clinical Policies and Procedures) where the various methods of preauthorization are detailed.

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Mental Health Benefits

	ADULT				CHILD			
	MEDICAID		INDIGENT		MEDICAID		INDIGENT	
	SMI	MH	SMI	MH	SED	NON SED	SED	NON SED
MENTAL HEALTH SERVICES								
Assessment	X	X	X	X	X	X	X	X
Outpatient Counseling	X		X		X	X	X	X
Mental Health Intensive Outpatient	X		X		X	X	X	X
Day Treatment	X		X					
Community Support Services	X		X		X	X	X	X
MH/CD Civil Commitment	X	X	X	X	X	X	X	X
Medication Services: Pharmacological Management	X	X	X		X	X	X	X
Injection Administration	X		X		X	X	X	X
Medications, including new generation medications	TMHP or STAR	TMHP or STAR	X	X	TMHP or STAR	TMHP or STAR	X	X
Laboratory services	TMHP or STAR	TMHP or STAR	X	X	TMHP or STAR	TMHP or STAR	X	X
Acute Inpatient Hospitalization	X	X	X		X	X	X	X
Sub-acute Inpatient Hospitalization	X	X	X		X	X	X	X
23-hour Observation Bed	X	X	X		X	X	X	X
Partial Hospitalization	X	X	X		X	X	X	X
Supported Employment	X		X					
Supported Housing	X		X					
Respite Care	X		X		X	X	X	X
Intensive Crisis Residential	X		X		X	X	X	X
Residential Treatment Centers	X		X		X	X	X	X
Personal Care Homes/Assisted Living	X		X					
Adult Foster Care	X		X					
Early Intervention					X	X	X	X
Early Childhood Preschool Day Treatment					X	X	X	X
Treatment Foster Care					X	X	X	X
Therapeutic Foster Care					X	X	X	X
MH Services – Birth to age 6					X	X	X	X
Children/Youth Wraparound					X	X	X	X
Mobile Crisis	X	X	X	X	X	X	X	X
Crisis Stabilization	X	X	X		X	X	X	X
Emergency Room Services (facility charges) -- for specialized behavioral health facility only *	X	X	X	X	X	X	X	X
Emergency Department Visits (charges by psychiatrists or other behavioral health professionals)	X	X	X	X	X	X	X	X
Transportation	TMHP or STAR	TMHP or STAR	X	X	TMHP or STAR	TMHP or STAR	X	X

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D. Covered Substance Abuse and Chemical Dependency Benefits

The Matrix on the following page summarizes the benefits that may be available to persons with substance abuse and chemical dependency diagnoses. **As with mental health benefits, not all consumers may be eligible for all covered services under this program** The covered benefits under the NorthSTAR Program include the benefits on the following page:

Please note: In order for a consumer to receive benefits under this plan, the consumer must meet medical necessity criteria. Also note that, with the exception of the first twenty SOP visits and three TIN (per member, annually effective September 1), all services must be preauthorized.

See Section IV (Clinical Policies and Procedures) where the various methods of preauthorization are detailed.

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SUBSTANCE ABUSE/CHEMICAL DEPENDENCY BENEFITS

	ADULT				SPECIAL POPULATIONS*	CHILD			
	Medicaid		Non-Medicaid			Medicaid		Non-Medicaid	
	CD	SA	CD	SA		CD	SA	CD	SA
CHEMICAL DEPENDENCY SERVICES									
Clinical Screening/Assessment	X	X	X	X	X	X	X	X	X
Hospital Inpatient Services	X	X	X	X	X	X	X	X	X
Hospital-based Detoxification	X	X	X	X	X	X	X	X	X
Medically Monitored 24-hour Detoxification	X	X	X	X	X	X	X	X	X
Medically Monitored Outpatient Detoxification	X	X	X	X	X	X	X	X	X
24-hour Residential Rehabilitation Program	X	X	X		X	X	X	X	X
Partial Hospitalization Rehabilitation Program	X	X	X	X	X	X	X	X	X
Intensive Outpatient Rehabilitation Program	X	X	X	X	X	X	X	X	X
Outpatient Program (minimum 2 hours/week by QCC)	X	X	X	X	X	X	X	X	X
Outpatient Service (minimum 1 hour/2 weeks by QCC)	X	X	X	X	X	X	X	X	X
Day Treatment	X	X	X	X	X	X	X	X	X
Pharmacological Maintenance	X	X	X	X	X	X	X	X	X
Specialized Female Services	X	X	X		X	X	X	X	X
Medications, including new generation medications	TMHP or STAR	TMHP or STAR	X	X	X	TMHP or STAR	TMHP or STAR	X	X
Laboratory Services	TMHP or STAR	TMHP or STAR	X	X	X	TMHP or STAR	TMHP or STAR	X	X
Transportation	TMHP or STAR	TMHP or STAR	X	X	X	TMHP or STAR	TMHP or STAR	X	X
Emergency Room Services (Facility charges)	X	X	X	X	X	X	X	X	X
Emergency Department Visits (MD services)	X	X	X	X	X	X	X	X	X

* Special populations include individuals with substance abuse/chemical dependency problems who fall into one of the following categories:

- Pregnant women
- Women with dependent children
- Parents of children in foster care
- IV drug users
- HIV + Individuals

NorthSTAR BENEFITS: DUAL DIAGNOSIS

Consumers who meet criteria for priority populations and who have a co-occurring mental health and substance abuse/chemical dependency diagnoses are eligible for all covered services on both mental health and substance abuse benefit charts.

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E. Pharmacy Benefits

NorthSTAR Enrollees who are covered by Medicaid are eligible to receive all prescription drugs through the existing Medicaid Drug Vendor Program. Medicaid prescriptions for adults are limited to three per month, unless the enrollee is a member of a STAR plan. Under the STAR plans, there are no monthly limits.

The NorthSTAR Program covers prescription medications for non-Medicaid enrollees if prescribed by a *ValueOptions* Network Provider. NorthSTAR enrollees must meet the target population, and medications will be covered by the *ValueOptions* NorthSTAR Drug Formulary.

Target Population:

296.00	296.01	296.02	296.03	296.04	296.05	296.06
296.40	296.41	296.42	296.43	296.44	296.45	296.46
296.50	296.51	296.52	296.53	296.54	296.55	296.56
296.60	296.61	296.62	296.63	296.64	296.65	296.66
296.7	296.80	296.89	296.20	296.21	296.22	296.23
296.24	296.25	296.26	296.30	296.31	296.32	296.33
296.34	296.35	296.36	295.10	295.20	295.30	295.40
295.60	295.70	295.90				

Our Pharmacy Benefits manual is available by request to any provider. It describes the specifics of our pre-authorization process and drug formulary.

F. Covered Services and Excluded Benefits

The following behavioral health services are **excluded** from the NorthSTAR benefits for Medicaid individuals, but are **covered** for eligible individuals in the applicable Medicaid program:

- Screening for behavioral health disorders during well adult checks
- THSteps exams and other ambulatory health exams
- Emergency medical transportation for behavioral health emergencies
- Behavioral health services provided by primary care physicians, other STAR physicians or other applicable Medicaid physicians within the scope of their licenses
- Behavioral health services provided by federally qualified health centers and rural health clinics
- Ambulatory laboratory services for persons who are Medicaid eligible
- Certain emergency room services, as described in Coordination of Care Agreements with Physical Healthcare Plans, which can be summarized as follows:

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- Behavioral Health professional services rendered by behavioral health specialists in the emergency room of a general acute care hospital, or a specialty psychiatric emergency room are covered by NorthSTAR as long as the following criteria are met:
 - Emergency room services are defined as services provided in the emergency room, treatment room, or observation room of a general acute care hospital or a specialty psychiatric emergency room.
 - Professional behavioral health services are services rendered by behavioral health practitioner types such as psychologists, psychiatrists, LPCs, LCSWs and LCDC licensed providers.
 - Services defined as emergency behavioral health conditions (see definition in Section XI (Definition/Glossary) of this Manual) are paid by *ValueOptions* whether rendered by a network or non-network provider.
 - Professional behavioral health services beyond emergency medical screening and medical stabilization are subject to authorization by *ValueOptions* to be eligible for reimbursement.
 - For NorthSTAR Enrollees with urgent and non-emergency conditions, *ValueOptions* require authorization for care beyond the medical screening exam and medical stabilization based on medical necessity.
- The STAR Plan covers all emergency room facility charges for behavioral health diagnoses, including any required ancillary services, unless the emergency room is a specialized behavioral health emergency facility.
- *ValueOptions* covers emergency room facility charges for behavioral health diagnoses, including any required ancillary services, in a specialized behavioral health emergency facility.
- NorthSTAR covers all inpatient behavioral health professional services based on medical necessity, regardless of primary diagnosis when provided by a behavioral health provider, as long as the following criteria are met:
 - Inpatient professional behavioral health services are services rendered by behavioral health specialist types such as psychologists, psychiatrists, LPCs, LCSWs and LCDC licensed providers while the client is in an inpatient facility. NorthSTAR is responsible for covering medically necessary behavioral health professional services provided while the enrollee is in an inpatient facility (freestanding psychiatric hospital or general acute care hospital), regardless of the primary diagnosis for the inpatient stay. *ValueOptions* requires the provider to obtain authorization for any non-emergency inpatient professional behavioral health services.
 - Inpatient behavioral health professional services rendered to NorthSTAR enrollees by non-network behavioral health specialists are covered in cases of a behavioral health emergency, when the service is unavailable in-network, or when the enrollee is

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- hospitalized while traveling outside the NorthSTAR service area. (Please refer to Section XI for definition of "emergency").
- STAR covers all inpatient professional services based on medical necessity, regardless of primary diagnosis when provided by a physical medicine provider. Please call the enrollee's STAR plan for preauthorization of these services.
 - STAR covers inpatient general acute **facility charges** when the consumer is treated on a medical unit.
 - NorthSTAR covers inpatient general acute facility charges when the consumer is treated on a psychiatric or substance abuse unit, as long as the following criteria are met:
 - NorthSTAR covers medically necessary inpatient facility charges when the primary diagnosis is for a behavioral health disorder rendered on a psychiatric or substance abuse unit. Behavioral health diagnoses are defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - Non-emergency inpatient behavioral health stays require preauthorization by *ValueOptions*, which covers the inpatient facility charge.
 - STAR covers medically necessary inpatient facility charges when the primary diagnosis is for a behavioral health disorder rendered on a medical unit. Please call the enrollee's STAR plan for preauthorization of these services.
 - In-patient facility charges for services rendered to NorthSTAR consumers by non-network facilities for a behavioral disorder treated in a psychiatric or substance abuse unit are covered in cases of emergency (when the service is unavailable in-network, or when the consumer is hospitalized while traveling outside the service area). Please note that *ValueOptions* will preauthorize all non-emergency care.

G. Ancillary Services

1. Inpatient Ancillary Services

The following policy on ancillary services applies to those enrollees who are covered by a STAR Plan:

- *ValueOptions* covers ancillary services provided while an enrollee is receiving inpatient care in a freestanding psychiatric facility.
- Ancillary services provided as part of a stay in a General Acute Care Facility are covered by the entity covering the inpatient stay. (This entity could be either the STAR plan or the NorthSTAR program).

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2. Ambulatory Ancillary Services

The STAR Plan covers medically necessary ancillary services ordered by physical medicine or behavioral health providers to screen, diagnose, and treat enrollees for behavioral health conditions. The criteria are listed below:

- Ancillary services include services such as lab tests, x-rays, and other medical tests.
- Ancillary services required in a behavioral health emergency (see definition in Section XI of this Manual) do not require authorization from *ValueOptions* or the STAR Program.
- Certain common ambulatory ancillary services may be ordered by the NorthSTAR behavioral health provider or the STAR primary care physician (PCP) without authorization from *ValueOptions* or the STAR plan. These services include:
 - Complete blood count, indices, and differentials
 - Biochemical profiles, including chemistries, renal, pancreatic, cardiac, and liver function tests
 - Blood work-ups for anemia and other blood cell effects, including vitamin B12, intracellular folate levels, glycosolated hemoglobin, etc.
 - Syphilis serology
 - HIV/AIDS testing
 - Tuberculosis testing
 - Breathalyzer and serum alcohol tests
 - Thyroid function tests
 - Cortisol levels and adrenal function tests
 - Stool guiac and occult blood
 - Urinalysis
 - Cultures and sensitivities on urine, blood, and body fluids
 - Pregnancy test, urine and serum
 - Pap smears
 - Drug levels, serum and urine
- For common laboratory tests, the behavioral health provider is required to contact the PCP to determine if usable test data already exists. The individual is also required to share information on test results with the PCP. The PCP, in turn, is required to share information on relevant lab tests with the behavioral health provider. Providers are responsible for getting a signed Release of Information form from the consumer, in order

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to share pertinent information. (Please see Section XIII, Required Forms, for a copy of the State-approved Release of Information form).

- The STAR Plan requires preauthorization for ancillary services NOT listed above. (Please see Section X for the contact numbers of each of the STAR plans).

Please note that NorthSTAR will include some Medicaid-eligible persons who are not enrolled in a STAR HMO. Some of these individuals will be enrolled in the Texas Health Network (THN), the State-administered plan. Others will receive their physical health services through the traditional Medicaid program. For those individuals enrolled in THN or the traditional Medicaid program, the provider should bill TMHP for these services. The provider must be enrolled in the Medicaid program to bill TMHP for covered services.

H. Procedures for Providers to Verify Enrollment and Eligibility

1. Overview

All Medicaid consumers are given the opportunity to enroll through Maximus. If a consumer fails to enroll in a BHO, the individual will be assigned to a BHO by the State. A consumer's enrollment period with a BHO begins as soon as the individual is enrolled. This enrollment period will end at any of the following events:

- The enrollee moves out of the service area
- The enrollee dies
- The enrollee is involuntarily disenrolled
- The enrollee's Medicaid category changes, making them ineligible for NorthSTAR

It is the responsibility of all network providers to verify a consumer's enrollment with *ValueOptions* prior to delivering non-emergency services. **Members will have an alpha-numeric identification number that is unique to NorthSTAR Enrollees.**

2. Provider Responsibilities

Providers are expected by the State to verify enrollment in a BHO. If a Medicaid or non-Medicaid consumer presents at your office and states that the individual is enrolled with *ValueOptions*, as a Network Provider, you may use our eProvider services by logging onto *ValueOptions.com* and accessing eProvider online services. You may also call our ACCESS LINE at **1-888-800-6799 (1-888-800-6792 for TDD)** and speak with one of our Enrollee and Provider Services Representatives to verify active enrollment. If current enrollment status is active, a provider should then follow the authorization procedures outlined in Section IV. When a provider verifies enrollment, a NorthSTAR-specific identification number will be given for each consumer. That NorthSTAR identification number must be used for all services, billing, and other interactions between *ValueOptions*, the provider and the consumer.

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3. Provider Six-Digit Identification Number

Providers may obtain their six-digit *ValueOptions* identification number by calling the ACCESS LINE and speaking to an Enrollee/Provider Services Representative. Identification numbers are also printed on Explanation of Benefit (EOB) forms sent with each provider claim payment.

4. eProvider Inquiries for Eligibility and Claims

Providers may access eProvider online services by logging onto *ValueOptions.com* to verify eligibility and claims status. Please refer to the eProvider manual or contact Provider Relations through the *ValueOptions* Access Line for assistance.

If a non-Medicaid consumer presents at your office and states that he/she is not currently enrolled in NorthSTAR, but that he/she wishes to be enrolled with *ValueOptions*, please refer the consumer to a designated enrollment site. If the provider is unsure of where the enrollment sites are located, please call our ACCESS LINE at **1-888-800-6799 (1-888-800-6792 for TDD)** and speak with one of our Enrollee and Provider Services Representatives to obtain a current list of enrollment sites. The enrollment site staff will complete a financial assessment on the consumer and fax the document to *ValueOptions* for pre-qualification. Once *ValueOptions* determines the consumer is qualified for enrollment into NorthSTAR, based on the financial information and the demographic information, *ValueOptions* will notify the enrollment site of the consumer's eligibility to receive services and provide a NorthSTAR ID number.

4. NorthSTAR MH/SA Enrollment Identification

As *ValueOptions* receives enrollment information from Maximus, we will send new enrollees an Enrollee Handbook. Since enrollees are able to move between any BHO at will, the only accurate way for providers to verify enrollment and eligibility is to take one of the steps outlined in the above paragraphs.

I. Involuntary Disenrollment

ValueOptions may request that a consumer be involuntarily disenrolled due to certain specific criteria. These criteria include the following:

- Severe disruptive behavior not caused by a behavioral health condition at a network provider's office.
- Fraudulent loaning of an enrollee's Medicaid card.
- Non-compliance with the financial and/or clinical assessment forms.
- Resolution of an emergent condition for an out-of-area enrollee.
- Enrollee no longer meets residential eligibility criteria.

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- Enrollee no longer meets financial eligibility criteria.

All involuntary disenrollments must be approved by the state. Consumers may appeal the involuntary disenrollment through the Appeals, Complaints, and Grievance Procedures described in Section VI of this Manual.