

Newborn Screening Benefits Program Contractor Procedures Manual



Department of State Health Services

Newborn Screening Unit

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**Newborn Screening Benefits
Contractor Procedures Manual**

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INTRODUCTION

- ✓ Purpose of the Manual
- ✓ Program Overview
- ✓ Process Description
- ✓ Medical Providers Qualifications
- ✓ Laboratory Provider Qualifications
- ✓ Pharmacy Provider Qualifications
- ✓ Dietary supplements Qualifications (including low-protein diet foods)

Purpose of Manual

The Department of State Health Services (DSHS) Contractor Procedures Manual for the Newborn Screening (NBS) Benefits Program provides guidance for contractors who deliver services using NBS Benefits Program funds in Texas. To provide services through the NBS Benefits Program, contractors are required to be in compliance with the requirements in this manual.

Program Overview

In 2005, during the Regular Session of the 79th Legislature, House Bill 790 was passed requiring expansion of the newborn screening panel to the American College of Medical Genetics (ACMG) recommended core panel, as funds allowed. Effective December 2006, the program began screening for 27 disorders. Increasing the panel from 7 to 27 disorders led to an increase in the number of presumptive positive screens as well as a greater need for confirmatory testing, evaluation, and treatment services. In December 2009, the program added Cystic Fibrosis to the newborn screening panel thus bringing the total number disorders screened for to 28.

The legislation resulted in the adoption of Texas Administrative Code (TAC), Title 25, Chapter 37 – Maternal and Infant Health Services, Subchapter D - Newborn Screening Program (§§37.51-37.65), which details the disorders for which newborns are screened; responsibilities of providers and parents; screening procedures; the provisions of follow-up care; and the provision of services to provided through program benefits for specified populations.

In order to meet increased needs for services, DSHS entered into an open enrollment process to procure the services from public and private providers. The NBS Benefits Program began operating in March 2007. The program offers reimbursement to enrolled providers for the provision of specified services to eligible clients at Medicaid rates for clinical services and NBS Benefits Program rates for remediation services, as program funding allows. The program provides services to eligible clients in accordance with 25 TAC §§37.51-37.65.

The NBS Benefits Program is comprised of four categories of service providers:

1. medical providers
2. laboratories
3. pharmacies
4. providers of low-protein diet foods

The services to be provided are:

1. clinical evaluations and follow-up care
2. confirmatory laboratory testing
3. medications
4. vitamins
5. dietary supplements (including low-protein diet foods)

Process Description

Texas newborns are mandated to receive two newborn screens. The first screen is completed within 24 to 48 hours after birth. The second screen is obtained within one to two weeks of age. Blood specimens from infants are analyzed by the DSHS Laboratory in Austin. Abnormal results are reported by the Laboratory staff to the NBS Case Management staff. Case Management staff provide follow-up to assist in linking families to health care providers who can confirm test results and ensure appropriate treatment.

Initial notification of abnormal results is made to the primary care provider (PCP) who may refer cases to a specialist, or consultant.

In cooperation with the PCP, specialist, or other health care practitioner, and within the limits of available funding for this purpose, the NBS Benefits Program will provide confirmatory testing, dietary supplements (including low-protein diet foods), medications, vitamins, and follow-up care at no cost or reduced cost to eligible clients. As specified in this manual, the NBS Benefits Program will reimburse public and private providers who are enrolled as NBS Benefits Contractors providing services to eligible clients at established rates.

Treatment(s) prescribed are to be provided by enrolled contractors in order for eligible clients to receive the program's benefits. The PCP, specialist, or other healthcare practitioner must consult the NBS Benefits Program list of enrolled laboratories, pharmacies, and providers of low-protein diet foods at the time of evaluation and prescription. The patient will be responsible for obtaining the prescribed treatment or lab tests from the enrolled pharmacy, laboratory, or provider of low-protein diet foods. The PCP, specialist, or other health care provider's office will serve as the intermediary for the client's services including providing follow-up to ensure client services have been provided.

Medical Providers Qualifications

The NBS Benefits Program is committed to assisting families in need of these services, and therefore has entered into open-enrollment contracts with Texas providers. To qualify for enrollment in the NBS Benefits Program, medical providers must be:

- Board Certified/Board Eligible physicians in Medical Biochemical Genetics, or Clinical Biochemical Genetics. Medical Geneticists who are physicians and boarded in Clinical Genetics are eligible, but must be able to document having been active in the management of patients with inborn errors of metabolism at least 25% of their time in the two years prior to submitting an application;
- Board Certified/Board Eligible Adult and Pediatric Endocrinologists (Adult-Endocrinology, Diabetes, and Metabolism), or Pediatric Endocrinology;

- Board Certified/Board Eligible Adult and Pediatric Hematologists (Adult-Hematology) or Pediatric Hematology (Hematology/Oncology);
- Board Certified/Board Eligible Adult and Pediatric Pulmonologists;
- Currently enrolled as a Medicaid Provider.

Laboratory Provider Qualifications

To qualify for enrollment in the NBS Benefits Program, *laboratories* shall:

- Be CLIA certified and must provide a copy of their CLIA certification attached to the application;
- Have the capacity to conduct confirmatory testing and follow-up testing for individuals identified through the Texas Newborn Screening Program as being at risk for a hereditary metabolic, endocrine, or hematologic disorder.

Pharmacy Provider Qualifications

To qualify for enrollment in the NBS Benefits Program, *pharmacies* shall:

- Ensure that they can provide medications, vitamins and dietary supplements prescribed by health care provider specializing in metabolic, endocrine, or hematologic disorders;
- Be a Class A (may include compounding pharmacies), a Class C (institutional pharmacy), a Class D (clinical pharmacy), or Class E (mail-order) pharmacy. Evidence of licensure must be provided with the enrollment application.

Low-Protein Diet Food Providers Qualifications

To qualify for enrollment in the NBS Benefits Program, providers of low-protein diet foods may be manufacturers or retailers of low-protein diet foods. Both manufacturers and retailers must supply their tax ID number and their license/permit number (if appropriate).

SECTION 1: ELIGIBILITY

- ✓ Who is Eligible for the Newborn Screening Benefits Program?
- ✓ What is the Eligibility Process?
- ✓ Screening and Eligibility Determination Form
- ✓ Eligibility Determination
- ✓ Appeal of Eligibility Determination
- ✓ Presumptive Eligibility
- ✓ Cautions Regarding Eligibility
- ✓ Client Responsibilities
- ✓ Contractor Responsibilities
- ✓ Mandatory Documentation
- ✓ Annual Re-Certification

WHO IS ELIGIBLE FOR THE NBS BENEFITS PROGRAM?

Depending on available funding, the NBS Benefits Program funded benefits (herein after referred to as benefits) shall be limited to specific populations of individuals who have an inheritable disorder detected through the program; whose income is at or below 350% of the federal poverty income level (FPL); and who are not eligible for other programs or funding sources that reimburse for a service. Eligible clients will receive confirmatory testing, evaluation, vitamins, dietary supplements, medication, and follow-up care as needed at no cost or reduced cost. **An annual application for admission to the program is required.** Per 25 TAC, Chapter 37, §§37.51-37.65, to be eligible to receive benefits and confirmatory testing, an individual must:

1. Have a positive presumptive screen of a disorder screened by the NBS Program, or have a confirmed diagnosis of an inheritable disorder included in those screened by the DSHS NBS Benefits Program;
2. Be a bona fide resident of the state;
3. Have a family income at or below 350% of the most current FPL;
4. Make financial participation payments in a timely manner (if required);
5. Provide updated medical, financial, residency information and/or documentation upon request from the benefits program;
6. Be otherwise uninsured for the same service provided;
7. Have a parent, managing conservator, or guardian agree to abide by these eligibility requirements if the individual is a minor.

An individual is eligible to receive remediation services, including dietary supplements, (including low-protein diet foods), medications, vitamins, and follow-up care, as needed, if the individual has a confirmed diagnosis of a disorder screened by the NBS Program, and continues to meet the eligibility criteria listed above in items two through seven. Income information must accompany the individual's completed application.

Depending on available funding, program benefits will be provided to the following populations, who meet all the eligibility criteria listed in this section, in the following order:

1. Children 0-2 years of age
2. Children 3-5 years of age
3. Children 6-21 years of age
4. Pregnant women
5. Women of child bearing age
6. Adults (female or male)

An individual is *not* eligible to receive benefits at no cost or reduced cost if the individual or the parent, managing conservator, or other person with a legal obligation to support the individual is eligible for other benefits, such as Medicaid, CSHCN, CHIP, CHIP Perinatal, Title V Genetic Services, or private insurance that can reimburse a service. To the extent that a funding source does not pay for confirmatory testing, or prescribed

remediation services, the NBS Benefits Program *may* pay for the service. Each case is evaluated on an individual basis.

DSHS may waive ineligibility if DSHS finds good cause for the waiver is indicated; and enforcement of the requirement prohibits, disrupts the administration, or prevents the provision of services to an otherwise eligible recipient.

When an application for services is filed, or at any time, if an individual is eligible for or receiving services, the applicant or recipient shall inform DSHS of any other benefit to which the applicant, recipient, or person with a legal obligation to support the applicant or recipient may be entitled.

WHAT IS THE ELIGIBILITY PROCESS?

The eligibility process consists of the following steps to determine and maintain benefits:

1. **Screening and Eligibility** – this step requires the completion of the *Screening and Eligibility Determination Form for Medical Services Assistance* to determine program eligibility, and signing the *Statement of Applicant's Rights and Responsibilities*. Individuals must be screened for potential Medicaid, CSHCN, CHIP, CHIP Perinatal, or other programs, and if potentially eligible, referred to the appropriate resource. Any applicant whose application screening indicates a “*not potentially eligible*” for a particular resource has the option to pursue further consideration with that particular resource, and be referred upon request.
2. **Annual Re-certification** – this required step is the annual eligibility review, which is prompted by the anniversary date on which the client was determined eligible for benefits
3. **Presumptive Eligibility** – this step requires the completion of the *Presumptive Eligibility Form for NBS Benefits Program*, and the *Statement of Applicant's Rights and Responsibilities* form completed and signed by the client, the identification of the contracting specialist provided, and signed by the coordinating provider (contractor, nutritionist, nurse, or social worker). These forms are submitted, when ***an immediate medical need*** is identified by the contracted specialist.
4. **Request for Waiver of Ineligibility** – this required step includes the submission of a *Newborn Screening Benefits Program Waiver of Ineligibility* form.

Eligibility for NBS Benefits Program funded benefits is exclusive of eligibility for other medical assistance programs, providing funding for the same services.

SCREENING AND ELIGIBILITY DETERMINATION FORM

The applicant or parent/managing conservator/guardian (in the case of a minor child) is responsible for completing page one of the Screening and Eligibility Determination Form for Newborn Screening Benefits Program, hereafter referred to as the *Screening and Eligibility Form*. If assistance is needed in completing the *Screening and Eligibility Form*, the family should contact the coordinating provider (i.e. contractor, nutritionist, nurse, or social worker) or NBS program for assistance. The applicant is responsible for providing documented evidence of eligibility. Failure to provide requested information will result in denial of eligibility.

Family composition, residency, and income are fully described below, including definitions and examples of supporting documentation.

Family Composition

Establishing family size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members.

Definition

A family is defined as a group of people who live together, with one or more of the persons being legally responsible for support of the other person(s).

Children Living with Relatives Other Than Parents

A child may be considered part of a family when living with relatives other than natural parents, if documentation is provided which proves the dependent relationship. If the child is not biologically related to the care provider, document the relationship on the *Screening and Eligibility Form*.

Documentation

For proof of dependency, one of the following items should be provided:

- birth certificate,
- baptismal certificate,
- school record, or
- other documents or proof of dependency, such as the most current income tax return, determined valid by the provider to establish the dependency of the family member upon the client or household head.

Residency

To be eligible for benefits, an individual must be a Texas resident, as defined below.

Definition

A Texas resident is an individual who:

- Is physically present within the geographic boundaries of the state;

- Does not claim residency in any other state or country;
- If under 18 years of age, the parent/guardian is a resident of Texas.

An individual with no fixed residence or new residency in Texas who declares intent to remain in the state may be served. Signing the *Statement of Applicant's Rights and Responsibilities* provides evidence of this intent. There is no duration requirement of residency for benefits.

Ineligible Individuals

Although the following individuals may reside in Texas, they are not considered Texas residents for the purpose of receiving services and are considered ineligible for the program:

- ✗ Persons who move into the state solely for the purpose of obtaining health care services;
- ✗ Students primarily supported by their parents, whose home residence is in another state;
- ✗ Inmates of correctional facilities;
- ✗ Residents of state or federal schools;
- ✗ Patients in federal institutions or state psychiatric hospitals.

Documentation

One of the following items is required to prove residency:

- valid Texas Driver's License,
- current voter registration,
- rent or utility receipts for one month prior to the month of application,
- motor vehicle registration,
- school records,
- property tax receipt,
- other documents considered valid by the provider, or
- mail addressed to the applicant, his/her spouse, or children if they live together.

Income

To be eligible for the NBS Benefits Program, applicants must have a gross family income at or below 350% of the most current FPL.

Definition

Income is any type of payment that is of gain to a family. Income can be either earned or unearned.

Earned income is defined as gross monthly income received for a certain degree of activity or work, such as:

- ✓ wages, salaries and commissions,
- ✓ self-employment income (minus business expenses), and
- ✓ military pay and allowances.

Unearned income is payment received without performing work-related activities, including benefits from other programs. Unearned income includes:

- ✓ Social Security or SSI benefits, VA benefits, pensions, and annuities,
- ✓ public assistance (TANF),
- ✓ unemployment compensation,
- ✓ alimony and child support,
- ✓ dividends, interest, and royalties,
- ✓ income from property, and
- ✓ disability insurance benefits.

Exclusions

The NBS Benefits Program does not examine resources such as bank accounts, vehicles or real estate ownership when determining eligibility. One-time payments, such as monies derived from the sale of real or personal property, gifts, tax refunds, and insurance payments or compensation for injury are not considered income for the purpose of NBS Benefits Program eligibility determination.

Dependent Childcare Expenses

Dependent childcare expenses may be deducted from total monthly income in determining potential Medicaid, CHIP, Title V Genetic Services, and NBS Benefits Program eligibility. Allowable deductions include:

- Actual expenses up to \$200.00 per child per month for children under age 2;
- Actual expenses up to \$175.00 per child per month for children 2 to 12 (up to age 18 if child is disabled).

Documentation

All sources of earned and unearned income are included.

Sources of *earned income* documentation include:

- Copies of the most recent paychecks or paycheck stub/monthly employment earning statements for four consecutive pay periods;
- Most current income tax return;
- Employer's written verification of gross monthly income;
- Pension allotment award letters;
- Domestic relation printouts of child support;

- Notarized letter of support (unless person providing letter is present and can show identification);
- Unemployment benefits statement or letter from the Texas Employment Commission;
- Other documents of proof of income determined valid by the provider.

Sources of *unearned income* documentation include:

- Award letters, court orders or public decree to verify support payments;
- Notes for cash contributions.

If an individual is self-employed and has no supporting documentation, a signed statement from the individual may be accepted for a period of six months. NBS benefit coverage cannot be extended on subsequent applications without formal documentation of self-employment income.

ELIGIBILITY DETERMINATION

Eligibility determination criteria are residence, income, and ineligibility for other programs providing the same services. The final determination of eligibility for benefits is made by the NBS Benefits Program using the information provided on the *Screening and Eligibility Form*, supporting documentation and, if necessary, information provided during an interview. The NBS Benefits Program must consider each eligibility factor and document the basis for the eligibility decision on the Screening and Eligibility Form.

Upon approving an application, the NBS Benefits Program will review the *Statement of Applicant's Rights and Responsibilities*. The statement should then be signed by the client and staff representative, a copy given to the client, and a copy filed in the client's medical record. This form does not have to be re-signed unless there is a break in service longer than two years.

APPEAL OF ELIGIBILITY DETERMINATION

If an individual has been determined ineligible for benefits, and the applicant believes the information on which the decision was based was incorrectly considered, the applicant may appeal to the NBS Benefits Program. Applicants may appeal the program's decision to deny services within 30 days after receiving a denial. Appeals will be evaluated on a case by case basis. A request for an appeal must be in writing and sent by certified mail. Failure to respond will be deemed a waiver of appeal.

Date Eligibility Begins

An individual is entitled to services beginning with the date the completed application was submitted, provided it is approved. The NBS Benefits Program will notify the client, coordinating provider and contractor of the eligibility determination.

PRESUMPTIVE ELIGIBILITY

Individuals with ***an immediate medical need*** may receive benefits on a presumptive eligibility basis during a pending eligibility for benefits or another program. Presumptive eligibility is effective for ***no more than 60 days*** from the first contact date by the provider. The individual should be at or below 350% of the FPL, a Texas resident, and have an immediate medical need as determined by the provider. The *Presumptive Eligibility Form* must be completed, signed and dated by the applicant and the coordinating provider. The form must be sent/faxed to the NBS Benefits Program, and a copy retained in the client's record. A client shall be enrolled on a presumptive eligibility basis only once in a 12-month period.

If the individual has not completed or began the application process for the NBS Program Benefits or another program, the application process should occur during the time the individual is receiving services. If it is not medically possible, the contractor/coordinating provider will contact the NBS Benefits Program staff. The NBS Benefits Program staff will complete the eligibility process. If services are needed immediately and are not provided by another benefits program, services may be provided through the NBS Benefits Program during this 60-day period. If the client becomes Medicaid or CHIP eligible, the services must be billed to Medicaid or CHIP under the 60 days prior provision. The NBS Benefits Program staff should be notified of the change in an individual's eligibility status on a timely basis.

Under presumptive eligibility, an NBS Benefits Program contractor may bill in good faith. If the client is then considered eligible for another resource, the contractor should bill that resource for services provided. The contractor should then deduct this amount from the next purchase voucher submitted to NBS Benefits Program.

CAUTIONS REGARDING ELIGIBILITY

Clients Who Screen As Potentially Eligible For Other Benefits

NBS Benefits Program will work to ensure that individuals seeking benefits use other programs or funding sources first. If individuals are determined potentially eligible for other benefits, they will be referred by NBS Benefits Program to the specific programs to assist them in completing the eligibility determination process. Individuals potentially eligible for Medicaid or CHIP should be referred to the *Your Texas Benefits* website at <https://www.yourtexasbenefits.com/wps/portal> or 2-1-1 for comprehensive Medicaid or CHIP eligibility determination.

Applicants who are determined eligible or potentially eligible for CHIP also may be eligible for benefits during the waiting period until CHIP coverage begins.

Individuals who have been placed on the CSHCN Services Program waiting list may be eligible to receive benefits, as well as those individuals aging off the CSHCN Services Program.

Completing the Eligibility Process

Individuals applying for the NBS Benefits Program may not opt to use benefits without completing the eligibility determination process for other medical assistance programs for which they screened as potentially eligible. Individuals whose eligibility screening process results in potential Medicaid or CHIP eligibility, but who fail to fully complete the required application process for these resources will not be eligible to receive benefits beyond those services delivered during a 60-day presumptive eligibility period. NBS Benefits Program will make applicants aware that failing or refusing to complete the appropriate application processes will result in their determination as self-pay clients.

If an applicant is determined to be potentially eligible for Medicaid or CHIP, and cannot be determined eligible or potentially eligible for benefits, the applicant's disposition will be at the NBS Benefits Program's discretion. Services provided to these individuals on the initial visit and subsequent visits may not be billed to the NBS Benefits Program.

CLIENT RESPONSIBILITIES

The Applicant's Responsibility in Eligibility Determination

The applicant or parent/managing conservator/guardian (in the case of a minor child) is responsible for completing and signing the Screening and Eligibility Determination Form, and providing documented evidence of family composition, residency, and income. Failure to provide documentation will result in denial of eligibility.

The Client's Responsibility for Reporting Changes

An eligible individual must report changes in the following areas:

- family composition,
- income,
- residence,
- address,
- employment,
- medical, hospital, and other types of health insurance coverage, and
- receipt of Medicaid and/or other third-party coverage benefits.

Individuals may report these changes by mail, telephone, in person, or through someone acting on the individual's behalf. An individual remains eligible for 14 days after any known eligibility change(s) occurs. The contractor must document any reported changes in the client's record, and inform the NBS Benefits Program within 30 days of any reported changes.

CONTRACTOR RESPONSIBILITIES

Contractor Responsibility in Eligibility Determination

The contractor/coordinating provider will ensure that all eligibility determination forms are faxed/sent to NBS Benefits Program for eligibility determination. The contractor will:

- Provide assistance if the applicant needs help in completing the Presumptive Eligibility Form (if applicable), the Screening and Eligibility Determination Form for Medical Services Assistance, and the Statement of Applicant's Rights and Responsibility Form;
- Assist the individual in designating additional contacts to verify their eligibility information, if requested by the individual;
- Document oral designations of any additional contacts;
- Ensure that completed forms are sent/faxed to NBS Benefits Program;
- Document any reported changes and the date of the reported changes in the client's file;
- Inform NBS Benefits Program of any changes within 30 days.

Contractors may request that the NBS Benefits Program provide assistance to clients in the completion of the required forms.

NBS Benefits Program Responsibilities in Eligibility Determination

NBS Benefits Program will ensure the eligibility process is complete and that the client record includes all appropriate eligibility documentation. NBS Benefits Program will:

- Accept Screening and Eligibility Determination Form that has been appropriately completed, recording the date on which it was received;
- Ensure that documentation provided by the applicant is sufficient to make an eligibility decision, or specify an additional source required to make that decision;
- Advise the individual of his/her responsibility to report changes and the types of changes the individual must report for application approval and at each annual review;
- Determine the effect the reported changes have on the client's eligibility by re-screening and revising the client's Screening and Eligibility Form for Medical Assistance Services, or completing a new one;
- Inform applicants deemed ineligible for benefits of their right to appeal the eligibility determination to NBS Benefits Program if they believe that information was incorrectly considered;
- File completed/signed forms, denial letters and appropriate documentation in the client's record;
- Send or fax contractors for their files:
 - A copy of the approval/denial letters for Presumptive Eligibility, Screening and Eligibility Determination Form, Waiver of Ineligibility and subsequent updated applicant information to the contracted specialist /coordinating provider;

- Annual Re-certification is the annual eligibility review, which is prompted by the anniversary date on which the client was determined eligible for benefits.

Verification

Verification of information is generally not necessary unless contradictory or discrepant information is provided or the information does not sufficiently explain the circumstances to support an eligibility decision. The NBS Benefits Program will allow the individual an opportunity to resolve any discrepancy by providing documentation or designating a suitable contact to verify their information.

MANDATORY DOCUMENTATION FOR CONTRACTORS

Each client must have a case record with documentation of eligibility for benefits.

The client's record must contain the following eligibility documentation:

- A copy of the appropriate completed and signed application form (Screening and Eligibility Determination Form, Presumptive Eligibility, and Waiver of Ineligibility) with the eligibility decision notated on the form;
- Copies of all prescriptions (metabolic formulas, vitamins, meds, and low-protein foods);
- Copies of acceptable documentation establishing family composition, residency and income;
- Copies of denial letters from other programs, if applicable;
- A copy of the signed Statement of Applicant's Right and Responsibilities;
- Documentation of reported changes in the client's family composition, residency or income and its impact on eligibility, when applicable;
- Copies of all approval/denial letter sent by NBS Benefits Program to contractor; and
- Copies of all quarterly Client Procedure Reports and Productivity Reports.

Records Retention

NBS Benefits Program will maintain records documenting eligibility for four state fiscal years following the end of the contract term during which the records were created.

Confidentiality and Privacy

The contractor is responsible for ensuring that files and medical records are maintained in a secure location and that information gathered verbally or in writing remains confidential. Those staff members having access to client records should ensure that information in those records is kept confidential. In addition, the contractor must ensure that services are provided in a confidential setting. Employees should be aware that violation of the law in regard to confidentiality might result in civil damages and criminal penalties.

ANNUAL RE-CERTIFICATION

Eligibility for benefits will be determined by the NBS Benefits Program for each client **at least once every 12 months**.

Eligibility determination also will be repeated upon the occurrence of any factor impacting eligibility, such as a change in family composition or income, but must be repeated no less than annually for a client to continue to receive benefits.

A copy of the completed, signed, dated and approved Screening and Eligibility Form will be sent to the contractor/coordinating provider, and must be retained in the client's file.

Procedures for Recertification

The NBS Benefits Program will determine the system used to track client status and renewal of eligibility.

For each client being re-certified, NBS Benefits Program staff will assure the client completes a new Screening and Eligibility Form or revises their previous form with a new signature and date. In so doing, the client:

- Updates/verifies information regarding family composition, residency, and income;
- Reviews and signs a new Statement of Applicant's Rights and Responsibilities, if there has been a lapse in service longer than two years;
- Is notified of the eligibility determination.

NBS Benefits Program staff will assist clients who request help in completing forms or providing documentation. The contractor will retain copies of signed forms and copies of documentation in the client's record, when received from the NBS Benefits Program.

If re-certification has not been completed by the anniversary date, the individual record will be removed from active status and placed in the inactive files. The individual will be notified of the status change by NBS Benefits Program staff.

SECTION 2: ELIGIBILITY FORMS AND INSTRUCTIONS

- ✓ Screening and Eligibility Determination Form for Medical Services Assistance Instructions
- ✓ Screening and Eligibility Determination Form for Medical Services Assistance
- ✓ Statement of Applicant's Rights and Responsibilities
- ✓ Eligibility and Benefits by Federal Poverty Level (FPL)
- ✓ Presumptive Eligibility Form Instructions
- ✓ Presumptive Eligibility Form for NBS Benefits Program
- ✓ Statement of Applicant's Rights and Responsibilities
- ✓ Metabolic / Immediate Medical Need Prescription Request
- ✓ Instructions for Waiver of Ineligibility
- ✓ Waiver of Ineligibility
- ✓ Waiver Prescription Request

SCREENING AND ELIGIBILITY DETERMINATION FORM FOR MEDICAL SERVICES ASSISTANCE INSTRUCTIONS

The two-page Screening and Eligibility Determination Form for Medical Services Assistance is used to screen, determine potential eligibility, and document eligibility determination for medical services assistance programs, such as Medicaid, Children's Health Insurance Program (CHIP), Title V Genetic Services, NBS Benefits Program, or other funding sources. The form does not determine final eligibility or ineligibility for any programs other than Title V Genetic Services or NBS Benefits Program. Clients must be referred to other programs, such as Medicaid and CHIP, to determine eligibility and apply for services.

Instructions for Completing Page 1

To the greatest extent possible, page 1 should be completed, signed and dated by the applicant, or the applicant's representative.

1. The family composition chart should reflect a group of people who live together, with one or more of the persons being legally responsible for support of the other person(s). The needs, income, resources, and medical expenses of anyone in the budget group are considered in determining eligibility for the group. For the purposes of this screening tool, consider only the parent(s), caretaker, spouse, and children under age 18 who live together as a family. (See Section 1 of manual for more information on family composition).
2. The income chart should include any type of payment that is of gain to the family.
- 3-5. These questions collect information on other benefits received, as well as pregnancy status, to assist NBS Benefits Program staff in determining potential eligibility.

Instructions for Completing Page 2

1. Applicant reads the Statement of Applicant's Rights and Responsibilities.
2. Applicant signs and dates the Statement of Applicant's Rights and Responsibilities.
3. Contractor signs as witness to the applicant's signature.

Eligibility Items:

- **Family Composition:** Enter number of family members in each of the categories listed. Enter total number of family members in bolded box. Note type of documentation on form. Attach documentation.
- **Residency:** Incorporated into family composition chart. An "eligible alien" is a person who is not a US citizen, but has immigration documents. "Other person" may be an individual who is not a US citizen and has no immigration documents. Note type of documentation on form. Attach documentation.
- **Income:** Income is any type of payment that is of gain to a family. Income may be earned or unearned. Earned income is defined as gross monthly income received for a certain degree of activity or work. Unearned income includes payments received without performing work-related activities, including benefits from other programs such as Social Security, VA benefits, TANF, or unemployment. If actual or projected income is not received monthly, convert it to monthly using one of the following methods:
 - If paid weekly, multiply weekly salary by 4.33.
 - If paid every two weeks, multiply salary by 2.17.
 - If paid twice a month, multiply salary by 2.
 - Childcare expenses may be deducted from total income. Allowable deductions are actual expenses up to \$200 per dependent per month under 2 years of age and \$175.00 per dependent per month for children age 2 to 12 (up to age 18 if the child is disabled).
 - The Grand Total Income (gross monthly income) is equal to Total Earned Income added to Total Unearned Income minus Total Childcare Expense Deduction(s).
 - Title V Genetic Services and NBS Benefits Program do not consider assets when determining eligibility, but assets are considered for Medicaid, CHIP, and CSHCN.
- **Other Benefits:** Other benefits may include Medicaid, Medicare, SSI, or County Indigent Program, for example. Contractor staff should note other benefits received and/or denied by applicant and family members.
- **Special Circumstances:** If Coordinating provider is assisting family with form, may document any special circumstances not already noted in this section, if applicable.

Eligibility Determination:

NBS staff should use this section to document potential, as well as, final eligibility determination. NBS staff that completes the Eligibility Determination section on the bottom of page 2 must initial and date once final eligibility is determined, unless the applicant is referred to another service and does not return to the contractor.

SCREENING AND ELIGIBILITY DETERMINATION FORM FOR MEDICAL SERVICES ASSISTANCE

(To be completed by Applicant)

Client Name / Cliente /Nombre	Date of Birth/Fecha de nacimiento	Home Phone No./Teléfono de la casa	County/Condado
Mailing Address (Street or PO Box)/Dirección Postal (Calle o Apdo.)		City/Ciudad	ZIP/Zona Postal
Home Address, if different from above. Domicilio particular, si es diferente a la dirección de arriba.			
Diagnosis/Diagnostico:			
Physician Specialist's Name/Nombre de Especialista Doctoro		What type of benefits are you requesting?	

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives with you for which you are legally responsible. / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven con usted y es legalmente responsable.

Name Nombre	Sex Sexo Male/Female Hombre / Mujer	Date of Birth Fecha de nacimiento	Texas Resident Ciudadano de Texas Yes/ Sí or No	U.S. Citizen Ciudadano de EEUU Yes/ Sí or No	What Relation to you? ¿Parentesco con usted?
a.					MYSELF Yo mismo
b.					
c.					
d.					
e.					

2. A copy of the most recent year's tax return must be attached with this completed form. List all of your household's income below. Be sure to include the following: Government checks; money from work; school scholarships; child support; workers compensation; disability benefits and unemployment. Una copia de la ultima declaracion de impuestos del ano debera adjuntarse con este formulario. / Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo; becas de la escuela; manutención de niños, o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, una vez al mes?)

3. Do you, or does anyone in your household have any of the following? If yes, please circle which one:

¿Usted o alguien en su familia tienen alguno de los siguientes? En caso afirmativo, un círculo que:

Medicaid, Medicare, CHIP, health insurance, V. A., Tricare, Other If yes, please provide copy of your insurance card.
 (seguro de salud) (administración de los veteranos)

4. Are you – or is anyone in your household – pregnant? ¿Está usted o alguien de la unidad familiar embarazada?..... Yes/Sí No
 If Yes, who?/Si contesta "Sí," ¿quién? _____

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas. Me comprometo a dar al personal que verifica la elegibilidad toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad. Yo entiendo y acepto que al proporcionar información falsa puede resultar in que yo no califique y que tenga que devolver el pago al Programa.

Signature – Applicant / Firma – Solicitante	Date / Fecha	Signature – Applicant's Representative	Date / Fecha

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES
DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

By signing this application for assistance, I affirm the following:	Al firmar esta solicitud para recibir asistencia, yo afirmo lo siguiente:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.	La información escrita en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. El deliberadamente omitir información o el proporcionar información falsa podría dar lugar a que el Proveedor cancele los servicios a uno de los miembros de mi hogar, de mi familia o los míos propios.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).	Si yo omito información, dejo de proporcionar o me niego a proporcionar información o; proporciono información falsa o engañosa acerca de estos asuntos, podría requerírseme que reembolse al Estado el costo de los servicios recibidos, si acaso se determina que no califico para los servicios. Yo reportaré los cambios en la situación de mi hogar, de mi familia, que afecten la elegibilidad durante el período de certificación (cambios en el ingreso, en los miembros del hogar, en la familia y, cambios de residencia.)
I authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household/family or me.	Yo autorizo la divulgación de toda la información, incluyendo pero no limitada a, el ingreso y a la información médica, de parte de y para, el <i>Texas Department of State Health Services (DSHS) [Departamento Estatal de Servicios de Salud de Texas]</i> y, al Proveedor para poder determinar la elegibilidad, para poder cobrar o, proporcionar servicios en mi hogar, a mi familia o, a mí personalmente.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.	Entiendo y acepto que podría pedirme el Proveedor que proporcione comprobantes de cualquiera de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.	La cobertura de seguro de salud, incluyendo pero no limitada a seguro para un individuo o seguro de salud para un grupo de personas; los de membresía proporcionados por organizaciones para el mantenimiento de la salud [como HMO], <i>Medicaid, Medicare;</i> beneficios de la <i>Veterans Administration;</i> de la CHAMPUS y <i>Worker's Compensation</i> [beneficios de Compensación Laboral], deben ser reportados al Proveedor. Los beneficios provenientes de esos seguros de salud pudieran ser considerados como la fuente principal de pago de la atención de salud recibida. Por este medio yo, asigno al Proveedor cualquiera de dichos beneficios. También asigno el pago de los beneficios y servicios recibidos de parte de y, a través del Proveedor, directamente a los proveedores de servicios.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para el programa, se me va a requerir que vuelva a solicitar para recibir asistencia, por lo menos cada doce meses.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.	Soy residente legítimo de Texas o bien, dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país o bien, soy un dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.	Algunos programas proporcionan atención a través de proveedores aprobados por los programas. Yo entiendo y acepto que, para recibir beneficios de dichos programas, el tratamiento debe ser recibido a través de esos proveedores aprobados por el programa.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.	Yo entiendo y acepto que el criterio para la participación en el programa es el mismo para todos sin importar sexo, edad, discapacidad, raza o bien, origen de nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.	Yo entiendo y acepto que tengo el derecho de registrar una queja con relación al manejo de mi solicitud o con relación a cualquier acción tomada por el programa con HHSC Civil Rights Office de 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or is eligible or potentially eligible.	Yo entiendo y acepto que recibiré documentación por escrito concerniente a los servicios para los cuales mi hogar, mi familia o yo calificamos o, potencialmente lleguemos a calificar.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)	Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: <i>Government Code</i> , sección 552.021, 522.023 y 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.	Entiendo y acepto que el programa no proporciona pago por la atención de pacientes internos. Entiendo y acepto que yo debo hacer mis propios arreglos de atención en el hospital y que yo soy responsable por el costo de la atención.
Signature – Applicant / Firma – Solicitante Date / Fecha	Staff Signature Date
Approved NBS Representative Signature: Date	

PERCENT OF POVERTY INCOME LEVELS FOR 2010

Percent of Poverty Income Levels for 2009

In accordance with 25 TAC Rule §1.91, the department follows a standardized procedure for developing, distributing and implementing percent of poverty income guidelines based on U.S. Poverty Income Guidelines issued by the Secretary of HHS and published each year in the Federal Register. The table below shows the 2009 Percent of Poverty Income Levels, from 2009 Guidelines published January 23, 2009.

Family Size	Annual															Monthly														
	17%	21%	25%	50%	100%	133%	150%	185%	200%	225%	250%	300%	17%	21%	25%	50%	100%	133%	150%	185%	200%	225%	250%	300%						
1	\$1,842	\$2,275	\$2,708	\$5,415	\$10,830	\$14,404	\$16,245	\$20,036	\$21,660	\$24,368	\$27,075	\$32,490	\$154	\$190	\$226	\$462	\$903	\$1,201	\$1,615	\$1,822	\$2,247	\$2,429	\$2,732	\$3,036						
2	\$2,477	\$3,060	\$3,643	\$7,285	\$14,570	\$19,379	\$21,855	\$26,955	\$29,140	\$32,783	\$36,425	\$43,710	\$207	\$255	\$304	\$608	\$1,215	\$1,615	\$1,822	\$2,247	\$2,429	\$2,732	\$3,036	\$3,643						
3	\$3,113	\$3,846	\$4,578	\$9,155	\$18,310	\$24,353	\$27,465	\$33,874	\$36,620	\$41,198	\$45,775	\$54,930	\$260	\$321	\$382	\$763	\$1,526	\$2,030	\$2,289	\$2,823	\$3,052	\$3,434	\$3,815	\$4,578						
4	\$3,749	\$4,631	\$5,513	\$11,025	\$22,050	\$29,327	\$33,075	\$40,793	\$44,100	\$49,613	\$55,125	\$66,150	\$313	\$386	\$460	\$919	\$1,838	\$2,444	\$2,757	\$3,400	\$3,675	\$4,135	\$4,594	\$5,513						
5	\$4,385	\$5,416	\$6,448	\$12,895	\$25,790	\$34,301	\$38,685	\$47,712	\$51,580	\$58,028	\$64,475	\$77,370	\$366	\$452	\$538	\$1,075	\$2,150	\$2,859	\$3,224	\$3,976	\$4,299	\$4,836	\$5,373	\$6,448						
6	\$5,021	\$6,202	\$7,383	\$14,765	\$29,530	\$39,275	\$44,295	\$54,631	\$59,060	\$66,443	\$73,825	\$89,590	\$419	\$517	\$616	\$1,231	\$2,461	\$3,273	\$3,692	\$4,553	\$4,922	\$5,537	\$6,153	\$7,383						
7	\$5,656	\$6,987	\$8,318	\$16,635	\$33,270	\$44,250	\$49,905	\$61,550	\$65,540	\$74,868	\$83,175	\$99,810	\$472	\$583	\$694	\$1,387	\$2,773	\$3,688	\$4,159	\$5,130	\$5,545	\$6,239	\$6,932	\$8,318						
8	\$6,292	\$7,773	\$9,253	\$18,505	\$37,010	\$49,224	\$55,515	\$68,469	\$74,020	\$83,273	\$92,525	\$111,030	\$525	\$648	\$772	\$1,543	\$3,085	\$4,102	\$4,627	\$5,706	\$6,169	\$6,940	\$7,711	\$9,253						
9	\$6,928	\$8,558	\$10,188	\$20,375	\$40,750	\$54,198	\$61,125	\$75,388	\$81,500	\$91,688	\$101,875	\$122,250	\$578	\$714	\$849	\$1,698	\$3,396	\$4,517	\$5,094	\$6,283	\$6,792	\$7,641	\$8,490	\$10,188						
10	\$7,564	\$9,343	\$11,123	\$22,245	\$44,490	\$59,172	\$66,735	\$82,307	\$88,980	\$100,103	\$111,225	\$133,470	\$631	\$779	\$927	\$1,854	\$3,708	\$4,931	\$5,562	\$6,859	\$7,415	\$8,342	\$9,269	\$11,123						
11	\$8,200	\$10,129	\$12,058	\$24,115	\$48,230	\$64,146	\$72,345	\$89,226	\$96,460	\$108,518	\$120,575	\$144,690	\$684	\$845	\$1,005	\$2,010	\$4,020	\$5,346	\$6,029	\$7,436	\$8,039	\$9,044	\$10,048	\$12,058						
12	\$8,835	\$10,914	\$12,993	\$25,985	\$51,970	\$69,121	\$77,955	\$96,145	\$103,940	\$116,933	\$129,925	\$155,910	\$737	\$910	\$1,083	\$2,166	\$4,331	\$5,761	\$6,497	\$8,013	\$8,662	\$9,745	\$10,828	\$12,993						
13	\$9,471	\$11,700	\$13,928	\$27,855	\$55,710	\$74,095	\$83,655	\$103,064	\$111,420	\$125,348	\$139,275	\$167,130	\$790	\$975	\$1,161	\$2,322	\$4,643	\$6,175	\$6,964	\$8,589	\$9,285	\$10,446	\$11,607	\$13,928						
14	\$10,107	\$12,485	\$14,863	\$29,725	\$59,450	\$79,069	\$89,175	\$109,983	\$118,900	\$133,763	\$148,625	\$178,350	\$843	\$1,041	\$1,239	\$2,478	\$4,955	\$6,650	\$7,432	\$9,166	\$9,909	\$11,147	\$12,386	\$14,863						
15	\$10,743	\$13,270	\$15,798	\$31,595	\$63,190	\$84,043	\$94,785	\$116,902	\$126,380	\$142,178	\$157,975	\$189,570	\$896	\$1,106	\$1,317	\$2,633	\$5,266	\$7,004	\$7,899	\$9,742	\$10,532	\$11,949	\$13,165	\$15,798						
For each additional person, add:	\$635	\$786	\$935	\$1,870	\$3,740	\$4,975	\$5,610	\$6,919	\$7,480	\$8,415	\$9,350	\$11,220	\$63	\$66	\$78	\$156	\$312	\$415	\$468	\$577	\$624	\$702	\$780	\$935						

Source: "Annual Update of the HHS Poverty Guidelines." Department of Health and Human Services, *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201.

Prepared by: DSHS, FCHS, Office of Program Decision Support, January 2009.

Revised 02/27/09

PRESUMPTIVE ELIGIBILITY INSTRUCTIONS

PURPOSE

The Presumptive Eligibility Form should be completed when an applicant is in need of immediate medical services and cannot fulfill application requirements at the time. The purpose of the form is to document that an applicant appears to be eligible for benefits. The eligibility determination process will be completed as soon as the client is able, and within 60 days following the delivery of services.

PROCEDURE

When to prepare: complete for persons who are in need of immediate medical services, but time or lack of materials prevent screening and eligibility determination.

Number of copies: complete an original and keep a copy for your records.

Transmittal: give a copy of the form to the applicant with NBS Benefits Program contact information in order to complete the application process. Mail/fax the completed form with the signed Statement of Applicant's Rights to the NBS Benefits Program, and retain copies of the forms in the client's chart.

Form retention: keep the case record copy for four state fiscal years after services are rendered.

INSTRUCTIONS FOR COMPLETING THE FORM

1. Enter applicant name, name of legally responsible adult if applicant is a child, address and phone number where applicant (legally responsible adult) can be reached, date of birth, mailing address.
2. Enter physician specialist's name and phone number.
3. Enter the type of benefits requested (i.e. metabolic food or medication)
4. Applicant completes numbers 1 through 7.
5. Applicant and coordinating provider signs and dates the Presumptive Eligibility Form.
6. Print name of the contractor (i.e., metabolic specialist, endocrinologist or hematologist responsible for providing services to the client).
7. Applicant and coordinating provider (i.e., contractor, nutritionist, nurse, social worker) sign the Statement of Applicant's Rights and Responsibilities.
8. Copies of the signed forms are provided to the applicant. The original completed/signed Presumptive Eligibility Form and the Statement of Applicant's right is mailed/faxed to the NBS Benefits Program. Copies of the signed forms are kept in the applicant's record.

Mail/fax to:

NBS Benefits Program
MC 1918
P.O. Box 149347
Austin, TX 78714-9347
FAX: 512-458-7593

If applicant is approved for an immediate medical need, NBS Benefits Program contacts the provider. The provider then faxes a completed Metabolic / Immediate Medical Need Prescription Request to the NBS Benefits Program at the fax number above. NBS Benefits Program submits the prescription to the pharmacy.

Presumptive Eligibility – NBS Benefits

Name/Nombre	Home Telephone/Número de teléfono de la casa (If no phone, give number of person who can reach applicant/de no tener teléfono, proporcione el teléfono de la persona que pueda ponerse en contacto con el solicitante)
Date of birth/ Fecha de nacimiento	Mailing Address (Street or P.O. Box)/ Dirección Postal (Calle o Apdo.)
City/Ciudad ZIP/ código postal	Home Address, if different from above. Domicilio particular, si es diferente a la dirección de arriba.
Physician Specialist Name/Nombre de Especialista Doctoro	Telephone Number/Numero de teléfono
What Benefits are you requesting?	

I am in need of immediate medical benefits (medical foods, medications) from the Newborn Screening Benefits Program. I understand that within 60 days following the delivery of services, I will submit a completed application for eligibility determination. The information below is true, correct, and complete to the best of my knowledge.

(Estoy en necesidad inmediata de beneficios del Programa de Examen Médico de Recién Nacidos (medicos alimentos, medicamentos). Yo entiendo y acepto que dentro de 60 días después de recibir los servicios yo entregaré una solicitud completamente llena, para que se lleve a cabo la determinación de elegibilidad. La información arriba proporcionada es verdadera, correcta y completa según mi leal saber y entender.

1. **Are you or the person applying for services a resident of Texas?**
(¿Son residentes de Texas, usted o la persona que solicita servicios?)..... Yes/Si No
2. **I am eligible for Medicaid (if under age 21 yrs.)** Yes/Si No
(Soy elegible para Medicaid (si es menor de 21 años de edad)
3. **I am eligible for Children’s Health Insurance Program (CHIP)** Yes/Si No
(Soy elegible para el Programa de Seguro Médico para Niños) (CHIP)
4. **I am eligible for Children with Special Health Care Needs (CSHCN)** Yes/Si No
(Soy elegible para el Programa de Niños con Necesidades Especiales de Salud) (CSHCN)
5. **I have insurance (or HMO/PPO) coverage for formula** Yes/Si No
(Tengo seguro (o HMO / PPO) para la cobertura de formula)
6. **I have a gross family income at or below 350% of the most current Federal Poverty Level guidelines.** Yes/Si No
(Tengo un ingreso familiar bruto igual o inferior al 350% de los más actuales lineamientos del Nivel Federal de Pobreza)
7. **I was not able to complete the eligibility determination process for the Program at this time.** Yes/Si No
(En este momento, no me fue posible completar el proceso de determinación de elegibilidad para el Programa).

I understand that I will be contacted by the Department of State Health Services Newborn Screening Program within 60 days to complete a *Screening and Eligibility Form for Services Assistance*.

(Yo entiendo que seré contactado por el Programa de Examen Médico de Recién Nacidos del Departamento Estatal de Servicios de Salud dentro de 60 días para completar un formulario de selección y elegibilidad para servicios de asistencia.)

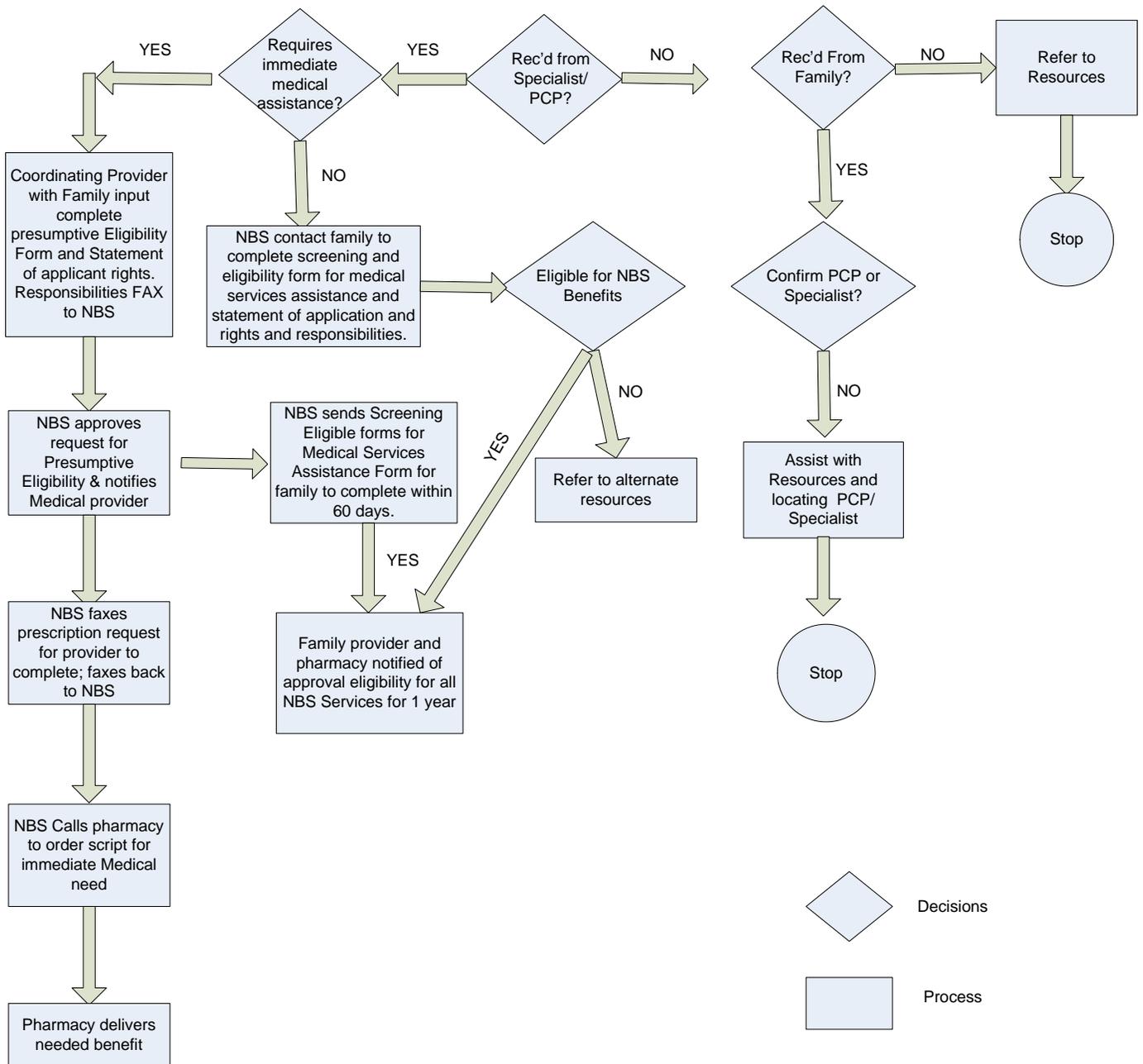
Signature – Applicant / Firma – Solicitante	Date / Fecha
Print Name of Contractor:	Date / Fecha
Signature – Contractor Staff / Firma – Oficinista	
Phone:	Fax:

Approved by NBS Representative Signature: _____ **Date:** _____

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES
DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

By signing this application for assistance, I affirm the following:	Al firmar esta solicitud para recibir asistencia, yo afirmo lo siguiente:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.	La información escrita en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. El deliberadamente omitir información o el proporcionar información falsa podría dar lugar a que el Proveedor cancele los servicios a uno de los miembros de mi hogar, de mi familia o los míos propios.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).	Si yo omito información, dejo de proporcionar o me niego a proporcionar información o; proporciono información falsa o engañosa acerca de estos asuntos, podría requerírseme que reembolse al Estado el costo de los servicios recibidos, si acaso se determina que no califico para los servicios. Yo reportaré los cambios en la situación de mi hogar, de mi familia, que afecten la elegibilidad durante el período de certificación (cambios en el ingreso, en los miembros del hogar, en la familia y, cambios de residencia.)
I authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household/family or me.	Yo autorizo la divulgación de toda la información, incluyendo pero no limitada a, el ingreso y a la información médica, de parte de y para, el <i>Texas Department of State Health Services (DSHS) [Departamento Estatal de Servicios de Salud de Texas]</i> y, al Proveedor para poder determinar la elegibilidad, para poder cobrar o, proporcionar servicios en mi hogar, a mi familia o, a mí personalmente.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.	Entiendo y acepto que podría pedirme el Proveedor que proporcione comprobantes de cualquiera de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.	La cobertura de seguro de salud, incluyendo pero no limitada a seguro para un individuo o seguro de salud para un grupo de personas; los de membresía proporcionados por organizaciones para el mantenimiento de la salud [como HMO], <i>Medicaid, Medicare</i> ; beneficios de la <i>Veterans Administration</i> ; de la <i>CHAMPUS</i> y <i>Worker's Compensation</i> [beneficios de Compensación Laboral], deben ser reportados al Proveedor. Los beneficios provenientes de esos seguros de salud pudieran ser considerados como la fuente principal de pago de la atención de salud recibida. Por este medio yo, asigno al Proveedor cualquiera de dichos beneficios. También asigno el pago de los beneficios y servicios recibidos de parte de y, a través del Proveedor, directamente a los proveedores de servicios.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para el programa, se me va a requerir que vuelva a solicitar para recibir asistencia, por lo menos cada doce meses.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.	Soy residente legítimo de Texas o bien, dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país o bien, soy un dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.	Algunos programas proporcionan atención a través de proveedores aprobados por los programas. Yo entiendo y acepto que, para recibir beneficios de dichos programas, el tratamiento debe ser recibido a través de esos proveedores aprobados por el programa.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.	Yo entiendo y acepto que el criterio para la participación en el programa es el mismo para todos sin importar sexo, edad, discapacidad, raza o bien, origen de nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.	Yo entiendo y acepto que tengo el derecho de registrar una queja con relación al manejo de mi solicitud o con relación a cualquier acción tomada por el programa con HHSC Civil Rights Office de 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or is eligible or potentially eligible.	Yo entiendo y acepto que recibiré documentación por escrito concerniente a los servicios para los cuales mi hogar, mi familia o yo calificamos o, potencialmente lleguemos a calificar.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)	Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: <i>Government Code</i> , sección 552.021, 522.023 y 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.	Entiendo y acepto que el programa no proporciona pago por la atención de pacientes internos. Entiendo y acepto que yo debo hacer mis propios arreglos de atención en el hospital y que yo soy responsable por el costo de la atención.
Signature – Applicant / Firma – Solicitante	Staff Signature
Date / Fecha	Date

NEWBORN SCREENING REFERRAL APPLICATION PROCESSES





**Texas Department of State Health Services
Newborn Screening Benefits Program**

METABOLIC / IMMEDIATE MEDICAL NEED PRESCRIPTION REQUEST

Date _____

Patient's Name: _____

Parent/Guardian: _____

DOB: _____

Address: _____

City: _____ Zip: _____

Current Telephone #: _____

Ship to address if different from above:

Name of metabolic food: _____

Quantity (2 month supply): _____ (list # cases)

Flavor (if applicable): _____

Pharmacy Name: _____

Other Medical Need:

Patient's diagnosis: _____ ICD-9 Code: _____

Printed name of Specialist _____

Specialist Signature _____

Telephone #: _____

Name of person completing form: _____

Title: _____

<p>Fax completed form to Benefits Program: 512.458.7593</p>
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INSTRUCTIONS FOR WAIVER OF INELIGIBILITY REQUIREMENTS FORM

The Newborn Screening Benefits Program may waive ineligibility if the department finds that good cause for the waiver is shown and enforcement of the requirement would tend to defeat or disrupt or prevent the provision of services.

1. Enter Client Name
2. Enter Client Address
3. Enter Client Phone Number
4. Enter Client Date of Birth
5. Enter Client's Diagnosis
6. Enter If Client Has Medicaid or Medicare & Enter the Number
7. Enter If Client Has Private Insurance or Private Pay*
8. Enter Type of Benefit Being Requested
9. Enter Explanation for Request of Waiver
10. Enter either the Specialists or Coordinating Provider's Signature and Date
11. Enter Client's signature (or legal representative) and Date
12. Fax waiver form to 512-458-7593

* If applicant has private insurance or private pay, the applicant must provide a copy of the most recent year's tax return.

Upon approval, the NBS Benefits Program provides written notification to the applicant, provider, and pharmacy/manufacturee that ineligibility has been waived for one year from date of approval.

If approved, the NBS Benefits Program will fax/e-mail the Waiver Prescription Request form to the referring provider. The provider completes the request form and faxes it to the NBS Benefits Program. The NBS Benefits Program contacts the pharmacy/manufacturee to establish an account for the client.



**NEWBORN SCREENING BENEFITS PROGRAM
WAIVER OF INELIGIBILITY REQUIREMENTS**

The Newborn Screening Benefits Program may waive ineligibility if the department finds that good cause for the waiver is shown and enforcement of the requirement would tend to defeat or disrupt or prevent the provision of services.

***NOTE:** All clients must fall within 350% of federal poverty level to be eligible for the waiver. If client is on CSHCN, he/she is **not** eligible for low protein foods on NBS Benefits Program. If client is on CSHCN waiting list, he/she **is** eligible for low protein foods.

To request a waiver of the program eligibility requirements, submit this form to the NBS Benefits Program via fax at 512-458-7593. **If approved, NBS Program will request ordering information.**

Client Name: _____

Client Address: _____

Client Telephone & Date of Birth: _____

Client's Diagnosis: _____

Medicaid/Medicare? no yes If yes, give # _____

Insurance Company name: _____

Private Insurance Or Private Pay? Private pay _____

Either must provide copy of most recent year's TAX RETURN

Benefit Requested: Metabolic formula Vitamins _____

Low protein foods Medicine _____

Explanation for Request of Waiver: _____

Client's Specialist/Coordinating Provider Signature: _____

Date: _____

Client's Signature: _____

Date: _____

For NBS Benefits Program Use Only

Request Approved: Effective dates: _____

Reason for Denial: _____

NBS Program Physician/Coordinator Signature: _____

Date: _____

Revised 9/30/09



**Texas Department of State Health Services
Newborn Screening Benefits Program**

WAIVER PRESCRIPTION REQUEST

Date _____

Client's Name: _____

Client's diagnosis: _____

Parent/Guardian: _____

DOB: _____

Address: _____

City: _____ Zip: _____

Current Telephone #: _____

E-mail Address: _____

Ship to address if different from above:

Low Protein Food: YES or NO

Period of Time: _____

Manufacturer Name:

Other Medical Benefits (Meds & Vitamins) _____

Quantity: _____

Period of Time: From: _____ To: _____

Pharmacy Name: _____

Contracted Provider (Physician/Facility): _____

Printed name of Dietitian _____

Dietitian's Signature _____

Telephone #: _____

**Fax completed form to Benefits
Program: 512-458-7593**

SECTION 3: ALLOWABLE NBS BENEFITS

- ✓ Evaluation and Management
 - New Patient Office Visit
 - Established Patient Office Visit
 - New/Established Patient Office Consultation
 - Genetic Evaluation and Counseling
 - Specialist Telephone Consultation
- ✓ Laboratory Procedures for
 - Metabolic Disorders
 - Endocrine Disorders
 - Hemoglobin Disorders
- ✓ Remediation Services for
 - Amino Acid Disorders
 - Organic Acidemias
 - Fatty Acid Oxidation Disorders
 - Endocrine Disorders
 - Hemoglobin Disorders

ALLOWABLE BENEFITS OVERVIEW

NBS Benefit Program contractors shall provide or assure the provision of benefits to include confirmatory testing, follow-up care, and remediation services for eligible clients. Confirmatory testing is indicated when an individual has a positive presumptive screen of a disorder screened by the NBS Program. Components include patient evaluation, one or more supplemental laboratory tests to substantiate or refute results of the screen, and if confirmed, management of the disorder. Remediation services include those dietary supplements (including low-protein diet foods), vitamins, and medications prescribed by the provider and deemed necessary for the treatment and management of the diagnosed disorder.

This section of the manual lists allowable services and procedure codes per procedure.

EVALUATION AND MANAGEMENT

Evaluation and management benefits are based on Medicaid established rates and limitations.

New Patient Office Visit

Physicians may use procedure codes 99201 through 99205 when billing for new patient services provided in the office, or in an outpatient or other ambulatory facility. Components include problem focused patient/family history, physical examination, and medical decision-making, with increasing levels of complexity and physician time with the patient and family. Below is the list of the standard New Patient Office Visit codes:

Codes
99201
99202
99203
99204
99205

Established Patient Office Visit

Physicians may use procedure codes 99211 through 99215 when billing for established patient services provided in the office, or in an outpatient or other ambulatory facility. Below are the standard Established Patient Office Visit codes:

Codes
99211
99212
99213
99214
99215

New or Established Patient Office Consultation

Physicians may use procedure codes 99241 through 99245 when billing for new or established patient consultation provided in the office, or in an outpatient or other ambulatory facility. Below are the standard Established Patient Office Consultation codes:

Code
99241
99242
99243
99244
99245

Medical Geneticist (Provider type 68) Visit/Consultation

Medicaid genetic codes can be used for reimbursement by medical geneticists (type 68 provider). The allowable codes are: 99245-TG, 99244-TG, and 99214-TG.

Specialist Telephone Consultations

Telephone consultations are considered a benefit if the clinician providing the client's medical home contacts a specialist for advice or a referral. The telephone consultation must be at least 15 minutes in duration. During the telephone call, the specialist assesses and manages the client's care by providing advice or referral to a more appropriate provider.

The following procedure code must be used with modifier U9 for a specialist telephone consultation.

Procedure Codes	
Procedure Code	Description
3-99499	Unlisted evaluation and management service (15 minutes)

Modifier	
Modifier	Description
U9	State Defined Modifier: Specialist telephone consultation

A specialist telephone consultation (procedure code 3-99499 with modifier U9) is limited to two consultations every six months. The specialist providing consultation, but not the clinician providing the medical home, will be reimbursed for consultation (note: the two allowable charges per six months are for each client by the same specialist).

Specialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services

Newborn Screening Benefits Program

(Specialist must keep copy on file)

Client name:	Time call started:
Date of birth: ____/____/____	Time call ended:
Parts A and B of this form must be completed and the form retained in the specialist's records.	
Part A	
Reason for call:	
The specialist's medical opinion:	
Recommended treatment or laboratory services:	
Physician's signature:	Date: ____/____/____
Physician name:	Physician's fax number:
Part B	
Referring medical home clinician:	Referring clinician's telephone number:

Instructions for Completion of the Specialist Telephone Consultation Form

The specialist must complete the Specialist Telephone Consultation Form and maintain supporting documentation in their records. The Specialist Telephone Consultation Form must be signed and dated by the specialist and must include the following information:

- Client's name, date of birth;
- Start and stop times indicating the consultation lasted at least 15 minutes;
- The reason for the call;
- The specialist's medical opinion;
- The recommended treatment and/or laboratory services;
- The name and telephone number of the referring clinician providing the medical home;
- The specialist's and referring clinician's identifier information;
- The name of the consulted specialist.

The specialist will submit the Specialist Telephone Consultation Form with a State of Texas Voucher for each client consultation provided per month (Section 4: Billing and Reporting).

LABORATORY PROCEDURES

Metabolic Disorders

Laboratory Test	Code
Urine acylglycines	82544
Urine amino acids	80500-52, 82139, 82570
Urine galactitol	82570, 84378, 83912
Urine homocysteine	83090
Urine quantitative organic acids	80500, 82541, 82542-22, 82570
Urine succinylacetone	82491, 82570
Plasma acylcarnitines	80500-52, 82017
Plasma quantitative amino acids	82139, 82492
Glutaric acid	82544
Plasma ammonia	82140
Plasma carnitine	82379-52, 83912-52
Plasma galactose	82760
Plasma homocysteine	83789x2
Plasma lactate/lactic acid	83605
Plasma methionine	82131
Plasma phenylalanine	84030, 84510
Plasma tyrosine	84030, 84510
Isoleucine challenge	83519
C16 and BCAA cell probes	82136
C16 and C18:1 cell probes	86300
RBC Gal-1-P	83912, 84378
WBC carnitine uptake	82379
DNA (A985G+ plus selected mutations) - MCAD	83891, 83901x2, 83904x4, 83894x2, 83898
DNA – IVD and SBCAD	83890
DNA sequencing - MCAD	83904x24, 83898x12, 83912, 83891
DNA – fumaryl acetoacetate hydrolase	82491, 82570
DNA – phenylalanine hydroxylase	83891, 83898x13, 83904-52x26, 83912
DNA – GALT	83891, 83894, 83900, 83901x12, 83912, 83914-22
DNA sequencing – LCHAD	83904x40, 83898x20, 83912, 83891
DNA (1528) – LCHAD	83890, 83892, 83894, 83898, 83912
DNA – MSUD	83891, 83898x30, 83904-52x60, 83912
Enzyme – GALT – quantitative	80500-52, 82664-52, 82775-52, 84311
Enzyme – MSUD - BCKD	80500, 82658-22, 88241-22
Enzyme – skin biopsy – MCAD	80500, 82657, 83912, 84311
Enzyme – 3OH-3CH3 glutaryl CoA lyase	84030
Enzyme assay RBC arginase	82657, 83026, 84520, 84311
Enzyme – skin biopsy – methylmalonyl CoA mutase	82657x2, 83898x12, 83904-22x24, 83912, 83921, 83891-52
Enzyme – skin biopsy - MCC	83891, 83900, 83901x3, 83909, 83912
Enzyme – propionyl CoA caboxylase	

	86738
Enzyme – skin biopsy – glutaryl CoA dehydrogenase	84999, 88233
Enzyme – skin biopsy – long chain hydroxy acyl-CoA thiolase	82261, 84999, 88233
Enzyme – skin biopsy – long chain 2-enoyl-CoA hydratase	80500, 82017
Enzyme – skin biopsy – VLCAD	80500, 82017
Enzyme – skin biopsy – LCHAD	82657, 84155, 88240, 88233
Enzyme – WBC – holocarboxylase synthetase	84999
Enzyme – skin biopsy – propionate incorporation studies	84999
Enzyme – skin biopsy – propionate incorporation studies and complementation analysis	84999
Enzyme – skin biopsy – BKT	82261
Enzyme – liver biopsy – argininosuccinate synthetase assay	82658, 82491, 84155
Enzyme – biotinidase	82261
Enzyme - fumarylacetoactase	82491, 82570

Endocrine Disorders

Laboratory Test	Code
T4	84436
Free T4	84439
TSH	84443
17-OH progesterone	83498
Electrolytes	84295, 84132
ACTH stimulation test	80402, 82533x2, 83498x2
Pregnanetriol	84138
ACTH	82024

Hemoglobin Disorders

Laboratory Test	Code
CBC	85007
Iron	83540
Liver function	80076
Hemoglobin electrophoresis	83020

Other laboratory procedures will not be reimbursed unless prior approval is obtained from the NBS Program.

REMEDIATION SERVICES

Upon receipt of the eligible client's completed/approved Screening and Eligibility Form, the NBS Benefits Program will send the applicant and coordinating provider a letter outlining the eligible benefits.

Following are lists of medications, dietary supplements, vitamins and low-protein foods indicated for the various disorders. The physician provider will determine the course of treatment for dietary supplements, medications, and vitamins; **the lists are provided for reference only.**

The provider is responsible for prescribing needed remediation services. The patient is responsible for procuring the prescribed medications, vitamins, and/or formula.

Dietary Supplements, Medications and Vitamins

Dietary supplements are prescribed by a physician when a patient has special nutrient needs in order to manage a disease or health condition, and the patient is under the physician's ongoing care. The label must clearly state that the product is intended to be used to manage a specific medical disorder or condition.

Dietary supplements are not meant to be used by the general public and may not be available in stores or supermarkets. Dietary supplements are not those foods included within a healthy diet intended to decrease the risk of disease, such as reduced-fat foods or low-sodium foods, nor are they weight loss products.

Dietary supplements are reimbursable at whole sale cost plus 15%.

There is a limit of \$1500.00 per month per client for dietary supplements.

There is a limit of \$300.00 per month per client for vitamins.

Amino Acid Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Homocystinuria/	Hominex-1 Hominex-2 HCY 1 HCY 2 HOM 2 XMet Analog XMet Maxamaid – orange flavor XMet Maxamum – orange flavor HCU Gel HCU Express Pro-Phree Super Soluble Duocal PFD 1 PFD 2 Cystine AA Supplement Pyridoxine Tablets (50 mg) Cystadane Powder (Betaine) Cyanocobalamin (vitamin B12)	Abbott Nutrition Abbott Nutrition Mead Johnson Mead Johnson Milupa Nutricia Nutricia Nutricia Vitaflo Vitaflo Abbott Nutrition Nutricia Mead Johnson Mead Johnson Vitaflo
MSUD (Maple Syrup Urine Disease)	MSUD Analog MSUD Maxamaid – orange flavor MSUD Maxamum – orange flavor Acerflex – pineapple flavor MSUD 2 BCAD 1 BCAD 2 Ketonex-1 Ketonex-2 Complex MSUD Drink Mix – vanilla Complex MSUD Amino Acid Bar – chocolate Complex MSUD Amino Acid Blend MSUD Gel MSUD Express MSUD Express Cooler MSUD Amino Acid Mix Pro-Phree PFD 1 PFD 2 Super Soluble Duocal Alanine AA Isoleucine AA Supplement Valine AA Supplement Thiamine	Nutricia Nutricia Nutricia Nutricia Milupa Mead Johnson Mead Johnson Abbot Nutrition Abbott Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Vitaflo Vitaflo Vitaflo Applied Nutrition Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Phenylketonuria - PKU	Phenex-1 Phenex-2 Phenex-2 – vanilla PhenylAde Drink Mix – vanilla PhenylAde Drink Mix – orange creme PhenylAde Drink Mix – vanilla strawberry PhenylAde Drink Mix – chocolate PhenylAde 40 Drink Mix – unflavored PhenylAde 40 Drink Mix – citrus PhenylAde 60 Drink Mix – Vanilla PhenylAde Essential Drink Mix – Chocolate	Abbott Nutrition Abbott Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Applied Nutrition

	Amino Acid Mix, Essential Buphenyl Powder Buphenyl Tablets Na Benzoate Powder Na Benzoate 10% Solution (100 mg/ml) L-Carnitine (100 mg/ml) Leucine Powder Isoleucine Powder Valine Powder Omeprazole	Ucyclyd Pharma Ucyclyd Pharma AstraZeneca
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Organic Acidemias Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Beta-Ketothiolase Deficiency (BKT)	MSUD Analog MSUD Maxamaid – orange MSUD Maxamum – orange Acerflex – pineapple MSUD 2 BCAD 1 BCAD 2 Ketonex-1 Ketonex-2 Complex MSUD Drink Mix – vanilla Complex MSUD Amino Acid Bar – chocolate Complex MSUD Amino Acid Blend MSUD Gel MSUD Express MSUD Amino Acid Mix Pro-Phree PFD 1 PFD 2 Super Soluble Duocal Isoleucine AA Supplement Valine AA Supplement	Nutricia Nutricia Nutricia Nutricia Nutricia Mead Johnson Mead Johnson Abbott Nutrition Abbott Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Glutaric Aciduria, Type I	Glutarex-1 Glutarex-2 Pro-Phree GA GA Gel - Unflavored PFD 1 PFD 2 Super Soluble Duocal XLys, XTrp Analog XLys, XTrp Maxamaid – orange XLys, XTrp Maxamum – orange Baclofen L-Carnitine	Abbott Nutrition Abbott Nutrition Abbott Nutrition Mead Johnson Vitaflo Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Nutricia Nutricia Parchem
Holocarboxylase Synthetase Deficiency/ Múltiple Carboxylase Deficiency	Biotin	
Isovaleric Acidemia	I-Valex-1 I-Valex-2 XLeu Analog XLeu Maxamaid – orange XLeu Maxamum – orange	Abbott Nutrition Abbott Nutrition Nutricia Nutricia Nutricia

	LMD Pro-Phree PFD 1 PFD 2 Super Soluble Duocal L-Carnitine (100mg/ml) Glycine	Mead Johnson Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Methylmalonic Acidemia/ Cobalamin A, B/ Homocystinuria	Propimex-1 Propimex-2 OA 1 OA 2 XMTVI Analog XMTVI Maxamaid – orange XMTVI Maxamum – orange Milupa OS 2 MMA/PA Gel MMA/PA Express Pro-Phree PFD 1 PFD 2 Super Soluble Duocal L-Carnitine (100 mg/ml) Hydroxocobalamin IM (1 mg/ml) Cyanocobalamin Tablets Cystadane (Betaine) – (1 gm/scoop)	Abbott Nutrition Abbott Nutrition Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Nutricia Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Methylmalonic Acidemia (Mutase Deficiency) - MUT	L-Carnitine Cyanocobalamin	
Propionic Acidemia	Propimex-1 Propimex-2 OA 1 OA 2 XMTVI Analog XMTVI Maxamaid – orange XMTVI Maxamum – orange MMA/PA Gel MMA/PA Express Pro-Phree PFD 1 PFD 2 Super Soluble Duocal Propionic Amino Acid Mix (TCH 92% AA) Leucine Powder Isoleucine Powder Valine Powder Biotin L-Carnitine	Abbott Nutrition Abbott Nutrition Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia

Fatty Acid Oxidation Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Carnitine Uptake Defect (CUD)	L-Carnitine	
MCAD	L-Carnitine	
Long-Chain Hydroxy-Acyl-CoA Dehydrogenase Deficiency (LCHAD)	L-Carnitine	
Trifunctional Protein Deficiency (TEP)	L-Carnitine	
Very-Long-Chain Acyl-CoA Dehydrogenase Deficiency (VLCAD)	MCT Oil L-Carnitine	
Biotinidase Deficiency	Free Biotin	

Endocrine Disorders

DISORDER	MEDICATION	MANUFACTURER
Hypothyroidism	Synthroid Levothroid Levoxyl	Abbott Laboratories Forest Pharmaceuticals Jones Pharma
CAH	NaCl (salt) Cortisone Fluorinef	

Hemoglobin Disorders

DISORDER	TREATMENT
Sickling Hemoglobinopathies	Penicillin Oxygen IV Fluids Antibiotics Analgesics Hydroxyurea Desoferrin

Cystic Fibrosis Disorder

Vitamins/Formula/Medications	MANUFACTURER
AquADEK	Axcan Scandipharm, Inc
Source CF	Cardinal Health Pharmaceuticals
Vitamax	Natures Products
ADEK	Axcan Scandipharm, Inc
Vitamin D: D2/Drisdol and D3	
Vitamin E	
Vitamin K/Mephyton	Aton Pharma Inc
Calcium	
Pediasure/Pediasure Enteral	Abbott Nutrition
Ensure/Ensure Plus	Abbott Nutrition
Scandishakes	Axcan Scandipharm, Inc
Peptamen Jr	Nestle Nutrition
Peptamen Jr 1.5	Nestle Nutrition
TwoCal HN	Abbott Nutrition
Neocate	Nutricia
Neocate Junior	Nutricia

<p> Elecare Nutren 1.5 Nutren 2.0 Nutren Jr Carnation Instant Breakfast Plus Carnation Instant Breakfast Very High Calorie Boost Kids Essentials Boost Kids Essentials 1.5 Boost/Boost Plus Ultrase Ultrase MT Creon Zenpep Pancrecarb Pancrease Pancrease MT Pancrecarb MS Viokase tablets Ursodiol Actigall Prevacid Zantac Prilosec Nexium Protonix Tobramycin (TOB 1) Pulmozyme Azithromycin Albuterol Xopenex Atrovent Spiriva Brovana Pulmicort Pro Air Ventolin Flovent Advair Symbicort Duocal Benecalorie Scandical Hypertonic Saline Lantus Novolog Humalog Glucose Testing Strips NPH </p>	<p> Abbott Nutrition Nestle Nutrition Axcan Scandipharm, Inc Axcan Scandipharm, Inc Solvay Pharmaceuticals Eurand NV Digestive Care, Inc. Ortho-McNeil Pharmaceutical, Inc Ortho-McNeil Pharmaceutical, Inc Digestive Care, Inc. Axcan Scandipharm, Inc Teva Pharmaceuticals USA Novartis Pharmaceuticals TAP Pharmaceuticals Inc GlaxoSmithKline AstraZeneca Pharmaceuticals, LP AstraZeneca Pharmaceuticals, LP Wyeth Pharmaceuticals Genentech GlaxoSmithKline Sepracor, Inc Boehringer-Ingelheim Pharmaceuticals Boehringer Ingelheim Pharmaceuticals Sepracor, Inc AstraZeneca Teva Speciality Pharmaceuticals GlaxoSmithKline GlaxoSmithKline GlaxoSmithKline AstraZeneca Canada Inc. Nutricia Nestle Nutrition Cardinal Health Pharmaceuticals Aventis Pharmaceuticals, Inc Novo Nordisk Pharmaceuticals Inc Eli Lilly and Co Eli Lilly and Co </p>
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Other Disorders

Galactosemia	<p> Enfamil Prosobee Lipil Similac Isomil Advance Good Start Supreme Soy Parent's Choice Soy Infant Formula with a Blend of Lipids </p>	<p> Mead Johnson Abbott Nutrition Nestle PBM Nutritionals </p>
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LOW - PROTEIN FOODS

The NBS Benefits Program may cover low protein foods for clients with an identified NBS disorder that prohibit them from eating a regular diet. For purposes of this policy, low protein foods are defined as follows:

- Must be lacking in the compounds which cause complications of the metabolic disorder;
- Are not generally available in grocery stores, health food stores, or pharmacies;
- Are not used by the general population;
- Are not foods covered under the SNAP Food Benefits (aka Food Stamps) program;
- Are products listed in enrolled providers' catalogs

Non-covered food items include but are not limited to the following items:

- Candy
- Candy covered items
- Chocolate
- Chocolate covered items
- Cookies
- Cakes
- Pies
- Dessert items
- Chips
- Onion rings
- Cookie dough
- Gum
- Cake mixes

Table B: Diagnosis Codes

2700 Disturbances of amino-acid transport
2701 Phenylketonuria (PKU)
2702 Other disturbances of aromatic amino-acid metabolism
2703 Disturbances of branched-chain amino acid metabolism
2704 Disturbances of sulphur-bearing amino acid metabolism
2706 Disorders of urea cycle metabolism
2707 Other disturbances of straight-chain amino acid metabolism
2708 Other specified disorder of amino acid metabolism
2719 Unspecified disorder of amino acid metabolism

Low-Protein Foods are reimbursable at retail cost.

There is a limit of \$200.00 for low-protein foods per client per month.

Low-protein foods will be obtained directly by the client. Contractors will fax the Waiver Prescription Request form to the NBS Benefits Program; manufacturer will be provided client's contact information by the NBS Benefits Program. The low-protein food manufacturer will bill NBS Benefits Program directly. For Waiver of Ineligibility applicants, please see Section 2.

Other dietary supplements will not be reimbursed unless prior approval is obtained from the NBS Benefits Program.

SECTION 4: BILLING AND REPORTING

- ✓ Billing Requirements
- ✓ Non-Reimbursable Expenditures
- ✓ Billing Errors
- ✓ Billing and Reporting Processes Flowchart
- ✓ State of Texas Purchase Voucher Instructions
- ✓ Purchase Voucher Example
- ✓ Form 1500 Insurance Claim Form Instructions
- ✓ Form 1500 Insurance Claim Form Example
- ✓ Reporting Requirements
- ✓ Maintenance of Records
- ✓ Client Procedure Report Form
- ✓ Quarterly Aggregate Client Report
- ✓ Contractor Clinical Services Assurance

BILLING AND REPORTING OVERVIEW

Contractors may only bill for services provided to clients who have been screened for potential Medicaid, CHIP, CHIP Perinatal, CSHCN, or Title V Genetic Services eligibility, and have been deemed eligible for NBS Benefits. See Section 1 of this manual for specific information on eligibility and billing.

Reimbursement for physician services and laboratory services are set at Texas Medicaid rates (See Section 3 of this manual for allowable services). Remediation services of dietary supplements are reimbursable at whole sale cost plus 15%. Remediation services of low-protein foods are reimbursable at retail cost. Contractors must submit documentation of purchasing remediation services at the whole sale price. Billing for shipping and handling will be reimbursed for any amount up to \$75.00 per order.

- There is a limit of \$1500.00 per month per client for dietary supplements.
- There is a limit of \$200.00 per month per client for low-protein foods.
- There is a limit of \$300.00 per month per client for vitamins.

BILLING REQUIREMENTS

Requests for reimbursement of allowable benefits at established rates are submitted monthly on a State of Texas Purchase Voucher, and a 1500 Health Insurance Claim Form. The voucher may be downloaded from:

<http://www.dshs.state.tx.us/grants/forms/b13form.doc>

The 1500 Health Insurance Claim Form may be downloaded from:

<http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf>.

Instructions for completing the State of Texas Purchase Voucher along with an example are found in this section.

Purchase vouchers must be submitted within **30 days** following the end of the month for which services are billed. For example, invoices for the month of February 2009 are due by March 31, 2009; invoices for March 2009 are due by April 30, 2009; invoices for April 2009 are due by May 31, 2009; and so on. Vouchers must include the payee identification number, the current document number, year, and attachment number in order to be processed.

Payments will be delayed:

- ✗ If the purchase voucher contains incorrect identification numbers or if the contractor fails to include these numbers on the voucher;
- ✗ If mathematical calculations are inaccurate;
- ✗ If payment is requested for unauthorized services;
- ✗ If client reports are not submitted with the purchase voucher.

NON-REIMBURSABLE EXPENDITURES

Contractors will only bill the NBS Benefits Program for services provided to individuals who meet the eligibility requirements of the NBS Benefits Program. Contractors will **not** request reimbursement for services provided to a client if:

- The individual is eligible for another program;
- The individual did not complete the eligibility process.

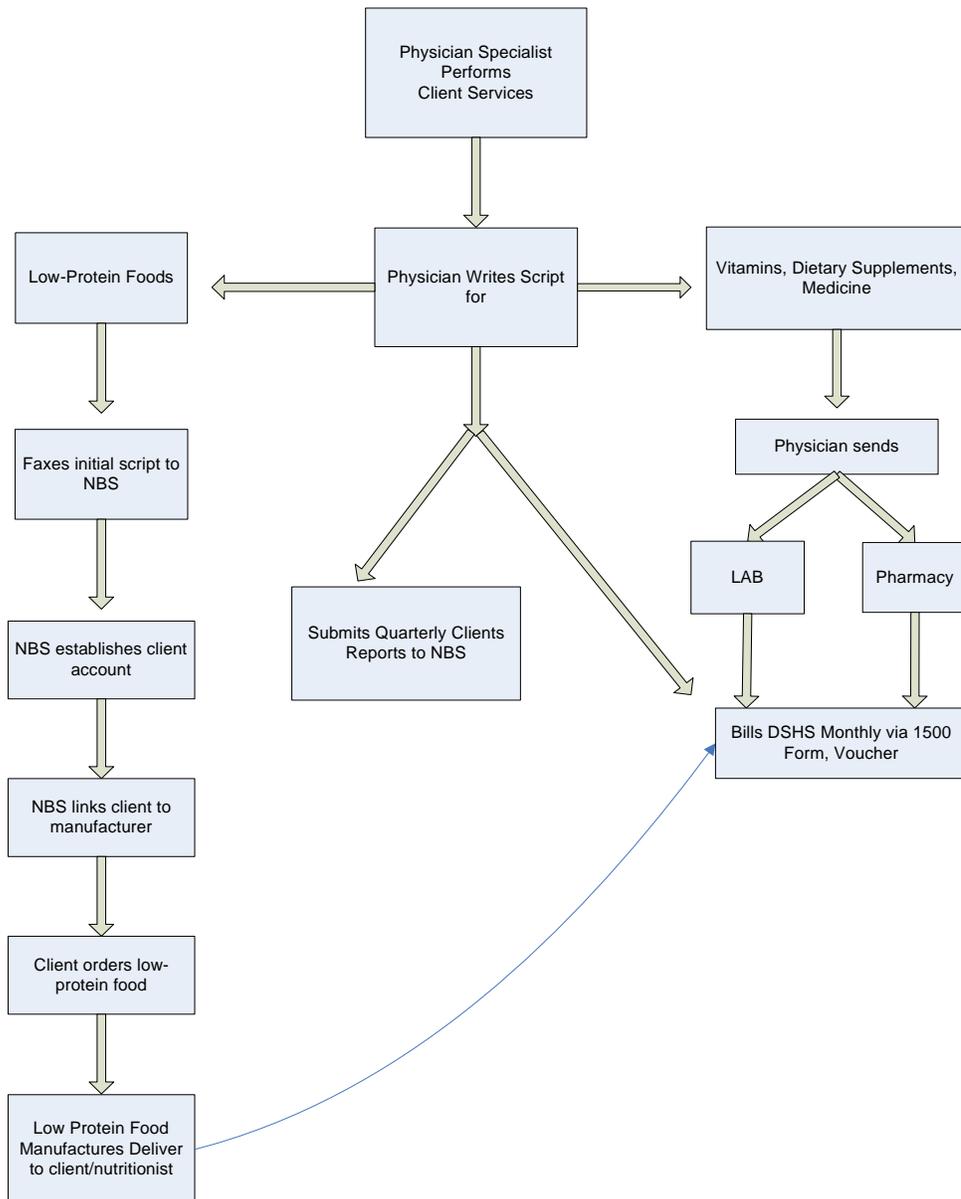
Services are often provided to individuals whose screening results indicate they are potentially Medicaid or CHIP eligible, but the client has not yet completed an application (with Medicaid or CHIP) or has not received notification of acceptance or rejection. The NBS Benefits Program may cover services delivered on the initial date of contact if the presumptive eligibility determination is in process. Once the client's denial letter from Medicaid and/or CHIP is received by the NBS Benefits Program, the contractor may bill for the services provided on the initial day of service as well as subsequent services.

BILLING ERRORS

Errors in billing may result in over or under payment for services provided. Errors that result in over billing can be corrected by submitting a revised voucher. For under billing, a supplemental voucher should be submitted along with supporting documentation (i.e., procedure code and new client reports). Clearly mark the words "Revised" or "Supplemental" on the purchase voucher. Explain changes and show calculations on the face of the voucher.

BILLING AND REPORTING PROCESSES FLOWCHART

Billing and Reporting Processes



STATE OF TEXAS PURCHASE VOUCHER INSTRUCTIONS FOR NBS BENEFITS PROGRAM

All sections listed below must be completed in order to receive payment.

SECTION	ENTRY
9. Payee Identification Number	Performing agency's 14 digit code number assigned by the State Comptroller's Office.
13. Document Amount	Amount for which performing agency is billing DSHS for the period indicated in section 19. (Must match reimbursement request in item 23).
14. Payee Name/Address	Performing agency's name, address, city, state, zip. Must coincide with section 9 (payee ID no.) and State Comptroller's Office records.
19. Ser/Del Date	The month and year in which costs were incurred.
20. Description of Goods or Services	Provide description to include: Name of product/service
21. Quantity	For Dietary Supplements and Vitamins - Amount of product in cans, pouches, or bottles
22. Unit Price	For Dietary Supplements -Whole sale cost per unit(can, pouch, or bottle)
23. Amount Reimbursement Statement:	Total expenses incurred for the period indicated in section 19 Net reimbursement request (same as document amount in section 13). Reimbursement for services as specified in the contract/manual between the Department of State Health Services and (name of performing agency) For Dietary Supplements, List: -Total whole sale cost for product -15% of total whole sale cost -Shipping and Handling and label as Shipping -Total amount of all services listed above* Low Protein Foods, List: -Total retail cost for product -Shipping and Handling and label as Shipping -Total amount of all services listed above
24. Contact Name	Enter name and phone number of person responsible for this account.

Complete all sections listed above and mail or email the voucher within 30 days following the end of the month for which services are being billed to:

*Reminder: Whole sale cost plus the 15% cannot go over \$1500 for dietary supplements and \$300 for vitamins.

Mail to:
DSHS Claims
PO Box 149347 – MC1940
Austin, Texas 78714-9347

Email to:
invoices@dshs.state.tx.us

STATE OF TEXAS PURCHASE VOUCHER

Comptroller
of Public
Accounts
Form

**DO NOT STAPLE OR WRITE
IN THIS SPACE.
BARCODE LABEL HERE.**

STATE OF TEXAS PURCHASE VOUCHER

Page 1 of 1

1. Archive reference number	2. Agency number 537	3. Agency name TEXAS DEPARTMENT OF STATE HEALTH SERVICES			4. Current document number
5. Effective date		6. Order (document) date	7. Due date	8. Doc Agency 537	
9. Payee identification number		10. PDT	623.76	12. Requisition number	
13. Document amount					

14. Payee name/address	15. GSC order number	17. AGENCY USE			
16. Lease number		Fund	Budget	Cat.	Service Date (Fiscal Use Only)
		Class	Project Grant	Program	

18. SFX	Ref Doc	SFX	M	TC	index	PCA	AY	COBJ	AOBJ	AMOUNT	R
001	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
Invoice number			Description					AGENCY USE			

18. SFX	Ref Doc	SFX	M	TC	index	PCA	AY	COBJ	AOBJ	AMOUNT	R
002	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
Invoice number			Description					AGENCY USE			

18. SFX	Ref Doc	SFX	M	TC	index	PCA	AY	COBJ	AOBJ	AMOUNT	R
003	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
Invoice number			Description					AGENCY USE			

19. SER/DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT

24. Contact name	Phone (Area code and number)	25. Entered by
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26. I approve this voucher for payment. The above goods or services correspond in every particular with the contract under which they were purchased. The invoice for the goods or services is correct. This payment complies with the General Appropriations Act.

Approved sign here *	Phone (Area Code and number)	Date
Fiscal Approved sign here *	Phone (Area Code and number)	Date

FORM 1500 HEALTH INSURANCE CLAIM FORM INSTRUCTIONS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional services by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by either employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kind commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bill.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 553e). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1982, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (8), and 44 USC 3101; 41 CFR 101 of sec and 10 USC 1079 and 1086; 5 USC 8101 of sec; and 33 USC 901 of sec; 38 USC 813; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 89-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-8, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: **PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1986, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0590. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

FORM 1500 HEALTH INSURANCE CLAIM FORM

1500

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

PCIA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) ERCA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE <input type="text"/> / <input type="text"/> / <input type="text"/> SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM!			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR ERCA NUMBER	
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
17a. NPI		11. INSURED'S POLICY GROUP OR ERCA NUMBER	
19. RESERVED FOR LOCAL USE		12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Fields Items 1, 2, 3 or 4 to Item 21b by Line)		SIGNED _____ DATE _____	
1. _____ 2. _____ 3. _____ 4. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
B. PLACE OF SERVICE EMS OP THROPS MODIFIER		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
C. PROCEDURES, SERVICES, OR SUPPLIES (Complete Unusual Circumstances)		22. MEDICAD RELEASUREMENT ORIGINAL REF. NO.	
D. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER	
E.		F. \$ CHARGES G. DATE OR DATE H. ICD-9-CM I. REFERRING PROVIDER ID. #	
1		25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO.	
2		27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3		28. TOTAL CHARGE \$	
4		29. AMOUNT PAID \$	
5		30. BALANCE DUE \$	
6		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)	
SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
33. BILLING PROVIDER INFO & PH # ()		33. BILLING PROVIDER INFO & PH # ()	

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Complete all sections listed above and mail or fax with State of Texas Purchase Voucher within 30 days following the end of the month for which services are being billed to:

DSHS Claims
MC 1940, P.O. Box 149347
Austin, Texas 78714-9347

Email to:
invoices@dshs.state.tx.us

REPORTING REQUIREMENTS

The **Individual Client Procedures Report** must be submitted to the NBS Benefits Program quarterly.

Instructions for Completing the Client Procedure Report

- ✓ Complete one form per NBS Benefits Program client **seen** during the quarter;
- ✓ At the top of the form, enter the contractor's name, the date on which services were provided, the provider's complete name, the client's complete name, and the client's date of birth;
- ✓ Check appropriate service provided under evaluation and management;
- ✓ For laboratory procedures, list the service description, CPT codes, and Medicaid rate;
- ✓ Enter the client's diagnosis;
- ✓ Enter the time spent with the client and the requested return time period.

Instructions for Completing the Productivity Report

- ✓ Enter facility/clinic name, physician's name, Person Completing Form and beginning and end date of the reporting quarter
- ✓ Enter total number of prescriptions written for each designated category for the reporting quarter
- ✓ Sign and date
- ✓ Fax, mail or e-mail to DSHS NBS Benefits Program

MAINTENANCE OF RECORDS

Contractors must maintain records that document the necessary information for services provided and billed for reimbursement. Documentation may be audited upon DSHS on-site quality assurance reviews. For guidance on financial administrative requirements, refer to the Financial Procedures Manual for DSHS Contractors, which may be found at

<http://www.dshs.state.tx.us/contracts/cfpm.shtm>.

**DEPARTMENT OF STATE HEALTH SERVICES
NBS BENEFITS PROGRAM CLIENT PROCEDURE REPORT**

Complete one form for each NBS Benefits Program Client seen during billing quarter

Contractor: _____ Contract #: _____

Date of service: _____ Provider: _____

Patient: _____ Patient DOB: _____

EVALUATION & MANAGEMENT SERVICES (check one)

New patient office visit:

- 99201 \$28.87
- 99202 \$45.56
- 99203 \$61.56
- 99204 \$90.07
- 99205 \$111.98

Established patient office visit:

- 99211 \$14.96
- 99212 \$25.04
- 99213 \$37.64
- 99214 \$52.86
- 99215 \$81.38

New/established office consultation:

- 99241 \$40.47
- 99242 \$70.25
- 99243 \$90.77
- 99244 \$127.28
- 99245 \$169.01

Genetic evaluation and counseling:

- 99245-TG \$370.48
- 99244-TG \$248.68
- 99214-TG \$81.10
- 99215-TG \$147.18
- 99213-TG \$50.76

Specialist Telephone Consultation:

- 3-99499 -U9 \$28.07

LABORATORY PROCEDURES (write name of test, code & rate; attach list as needed)

Name of test	Code(s)	Rate

DIAGNOSIS: _____

Duration of Office Visit: _____ Hrs. _____ Min.

Follow-Up: _____ Wks. _____ Months

<p>Mail/fax to:</p> <p align="center">Department of State Health Services NBS Open Enrollment MC 1918, PO Box 149347 Austin, TX 78714-9347 Fax: 512-458-7593</p>
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**DEPARTMENT OF STATE HEALTH SERVICES
NBS BENEFITS PROGRAM PRODUCTIVITY REPORT**

Complete one form for all prescriptions written for NBS Benefits Program Clients during the billing quarter.

Facility Name: _____

Physician's Name: _____

Staff Completing Form: _____

Quarter Dates: _____

Benefit Provided:

Total Prescriptions:

- Metabolic Formula
- Low-Protein Foods
- Vitamins
- Medication

SIGNATURE (person filling out form): _____

DATE: _____

Mail/fax to: Department of State Health Services NBS Open Enrollment MC 1918 PO Box 149347 Austin, TX 78714-9347 Fax: 512-458-7593
<u>E-mail to:</u> benefits@dshs.state.tx.us

CONTRACTOR CLINICAL SERVICES ASSURANCES

Contractors are required to comply with the DSHS Family and Community Health Services Division provisions as follows:

1. To provide benefits in a culturally sensitive and non-discriminating manner;
2. To provide benefits as outlined in the Scope of Work and the NBS Benefits Program Contractor Procedures Manual;
3. To return 100% of revenue collected as co-payments from clients, whose services are reimbursed with NBS Benefits Program funding, to Department of State Health Services, NBS Benefits Program, MC 1918, PO Box 149347, Austin, Texas 78714-9347;
4. To provide DSHS with access to all data gathered by the project, within constraints of client confidentiality;
5. To grant DSHS rights to tangibles, patentable or copyrightable products developed with NBS Benefits Program funding;
6. To comply with all policies and procedures contained in the NBS Benefits Program Contractor Procedures Manual.