

Newborn Screening Program Benefits

Contractor Procedures Manual



**Texas Department of State
Health Services**

Newborn Screening Program

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INTRODUCTION

General Information

PURPOSE

The Department of State Health Services (DSHS) Contractor Procedures Manual provides guidance to contractors who deliver services to eligible clients in Texas using Newborn Screening Program (NBS) Benefits. To provide these approved services, contractors are required to understand and know the terminology, applicant eligibility screening requirements and processes, and comply with specific federal and state laws and procedures outlined in the manual. This manual describes the qualifications for benefit service providers, the client eligibility process, billing and reimbursement.

Terms used throughout this document are defined in the [appendix](#) of the document for reference. Links are provided for the electronic use of this manual.

BENEFITS OVERVIEW

The Health and Safety Code, [Chapter 33](#), titled, Phenylketonuria, Other Heritable Diseases, Hypothyroidism, and Certain Other Disorders allows for limited benefits on the confirmation of a positive test for phenylketonuria, other heritable diseases, hypothyroidism, or another disorder for which the screening tests are required. These limited benefits are defined in rule in the Texas Administrative Code (TAC), Title 25, [Chapter 37 – Maternal and Infant Health Services, Subchapter D - Newborn Screening Program](#).

When abnormal results are reported by the DSHS Laboratory staff to the NBS Clinical Care Coordination (CCC) staff, they notify the primary care physician (PCP) of the abnormal results. The CCC staff can also assist with linking families to health care providers if necessary. The PCP may consult with or refer the newborn to a contracted physician.

If the contracted physician recommends services for a patient that may be eligible for benefits, an application should be submitted. If the specialist is not a contracted provider, the patient must be referred to a contracted physician to apply for benefits. When NBS Benefits approves the application, the applicant becomes a client and is able to receive covered services.

In cooperation with the contracted health care practitioners and within the limits of funds budgeted by the DSHS, NBS Benefits will provide the following benefits:

- Clinical evaluations and follow-up care
- Confirmatory, follow-up and monitoring; laboratory testing
- Medications
- Vitamins
- Dietary supplements
- Medical Foods (low protein foods and formulas)

These benefits are provided at no cost or reduced cost to individuals approved for NBS Benefits.

Newborn Screening Benefits does not cover durable medical equipment (DME).

Dependent on funding availability, benefits will be provided to a priority population 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)

To be eligible to receive NBS Benefits or services, an individual must meet the following criteria, except as otherwise provided for in the rules:

- Have an abnormal screening result (pending confirmation of diagnosis), or a confirmed diagnosis of a [disorder screened by the program](#) as referenced in [TAC §37.53 \(relating to Disorders for Which Blood Specimen Screening is Performed\)](#);
- Be a Texas resident;
- Have a family income that is at or [below 350% of the federal poverty income guidelines](#);
- If required, make financial participation payments in a timely manner;
- If requested by the program, provide current medical, financial, and residency information and/or documentation in a timely manner;
- Have a parent, managing conservator, or legal guardian agree to abide by the requirements in the rules if the individual is a minor; and
- Is not eligible for another benefit, such as Medicaid, CSHCN Services Program, CHIP, or private insurance that would pay for all or part of the benefits in question.

SECTION I: NBS BENEFITS PROVIDER QUALIFICATIONS

NBS BENEFITS PROVIDER TYPES AND SERVICES

In order to be reimbursed for services, a Texas provider must be enrolled as a contracted NBS Benefits provider. The DSHS open enrollment process is available to public and private providers for the provision of services to eligible clients in accordance with the NBS Program rules. Contracted providers are reimbursed at established rates within DSHS.

Go to <https://apps.hhs.texas.gov/PCS/HHS0001837/> for more information on the open enrollment process.

The services covered by NBS Benefits fall into four categories of providers or contractors:

- Physician Specialists
- Laboratories
- Pharmacies
- Manufacturers or Retailers of Medical Foods

To qualify for enrollment in NBS Benefits, the provider must meet qualifications for their respective provider type below:

PHYSICIAN SPECIALIST QUALIFICATIONS

Meet the following requirements if applying as a physician specialist:

- Must be currently licensed as a Medicaid Provider in Texas; and
- Board Certified/Board Eligible physicians includes active candidates of the American Board of Medical Genetics and Genomics, 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 past two years prior to submitting an application for enrollment); or
- Board Certified/Board Eligible Adult and Pediatric Endocrinology (Adult-Endocrinology, Diabetes, and Metabolism), or Pediatric Endocrinology; or
- Board Certified/Board Eligible Adult and Pediatric Hematology (Adult-Hematology) or Pediatric Hematology (Hematology/Oncology);
- Board Certified/Board Eligible Adult and Pediatric Pulmonology; or
- Board Certified/Board Eligible Allergy and Immunology.

LABORATORY PROVIDER QUALIFICATIONS

Meet the following requirements if applying as a laboratory:

- Be certified by Clinical Laboratory Improvement Amendments (CLIA);
- Must provide a copy of the CLIA certification attached to the application; and
- Have the capacity to conduct confirmatory testing and follow-up testing for patients identified through the Texas Newborn Screening Program as being at

risk for a hereditary metabolic, endocrine, or hematologic, pulmonology, or immunologic disorder.

PHARMACY PROVIDER QUALIFICATIONS

Meet the following requirements if applying as a pharmacy:

- Must be able to dispense medications, medical foods, vitamins and dietary supplements prescribed by an enrolled physician specialist; and
- Provide a copy of licensure with the enrollment application identifying pharmacy classification in one of the following:
 - Class A (may include compounding pharmacies),
 - Class C (institutional),
 - Class D (clinical), or
 - Class E (mail-order).

MEDICAL FOODS (MANUFACTURER OR RETAILER) PROVIDER QUALIFICATIONS

Meet the following requirements if applying as a manufacturer or retailer of medical foods

- Be a manufacturer or retailer of medical foods (low protein foods and formulas), dietary supplements and vitamins that are prescribed by an enrolled physician specialist
- Provide a catalog of low protein food products; and
- Provide the tax ID number and license/permit number, as appropriate, as part of its application.

SECTION II: CLIENT SERVICES, POLICIES AND PROCEDURES

ELIGIBILITY SCREENING - INITIAL SCREENING OF OTHER PROGRAMS OR BENEFITS

NBS Benefits is a payer of last resort and may cover services that are not covered by other program benefits or the individual's primary health plan. Contractors must work to ensure that individuals seeking NBS Benefits use other programs or benefits first. The other programs or benefits that must be used first include:

- Private/Employer Insurance
- Medicare
- Medicaid
- TRICARE
- Children with Special Health Care Needs Services Program (CSHCN)
- Children's Health Insurance Program (CHIP) (other than family planning services)

Important First Step: Applicants or clients potentially eligible for NBS Benefits must first apply for these other programs through Health and Human Services (HHS) initial screening process before applying to NBS Benefits. **This is a very important step prior to pursuing the NBS Benefits application.**

Applicants may access the HHSC "Your Texas Benefits" website (www.yourtexasbenefits.com) which contains information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and CHIP. Applicants may also access the DSHS CSHCN website (www.dshs.texas.gov/cshcn) for the application process for CSHCN. If the applicant is unsure of their eligibility for other financial resources, the applicant should call 2-1-1 assistance or be referred to a local Community Resource Center.

WAIVER OF INELIGIBILITY

Individuals who are covered by other program benefits may apply for a Waiver of Ineligibility if that program denies coverage of a NBS Benefits covered item and/or service. The contractor must first confirm that the other program does not pay for all or part of the item requested. Only after coverage is denied can the contractor apply for the waiver on behalf of the applicant. The contractor must complete and sign the waiver of ineligibility to be included with the required application documentation.

PRESUMPTIVE ELIGIBILITY

In some cases, a contracted physician can determine that a patient is in immediate medical need. This means the patient is unable to endure the delay of the application process before receiving approved benefits. When this occurs, the physician should start the presumptive eligibility process. The applicant declares that without proof, they are eligible for NBS Benefits. The presumptive eligibility period is for 60 days from the date the physician determined the immediate medical need.

The contracted physician's office will assist the applicant with the following:

- Presumptive Eligibility Application;
- Prescription Request Form;
- Statement of Rights and Responsibilities Form; and
- Waiver of Ineligibility Form, if applicable.

All fields in the application and forms must be complete and:

- Signed by the contracted physician,
- Emailed or faxed to NBS Benefits, and
- Copied for the patient and the originals retained in the patient's record.

NBS Benefits will issue an approval letter after confirming that presumptive eligibility exists. The letter will include an Applicant Packet to start the NBS Benefits process. During the presumptive eligibility period, the applicant must:

- Apply for other program benefits and receive a reply;
- Gather supporting documents;
- Complete the NBS Benefits application; and
- Submit to the contracted physician's office before the end of presumptive eligibility.

Applicants must apply for continued services before the 60-day presumptive eligibility period ends. If the application is not received and approved before the end of the 60-days, the applicant is ineligible for NBS Benefits and will be responsible for payment of services beginning the 61st day.

An individual can only be enrolled on a presumptive eligibility basis once in a 12-month period.

Applications received after presumptive eligibility ends will go through the standard review process. The applicant must await completion of the review to receive a new eligibility determination. There may be a gap in approved services, if approved.

When the contractor is aware that the client is eligible for other benefits or coverage, the contractor must immediately notify NBS Benefits. The contractor must bill the responsible program or insurance company for services provided during the approved presumptive eligibility period.

STANDARD APPLICATION PROCESS

When a patient is not in immediate medical need, the contractor will assist the applicant with the standard application process. The contractor must direct the applicant to apply for other program benefits first.

The applicant must receive the reply from the other programs before beginning the NBS Benefits application process.

The contractor will provide the patient with an [Applicant Packet](#). The packet includes:

- [NBS Benefits Application for Services](#), and
- [Statement of Applicant's Rights and Responsibilities](#).

The contractor will:

- Review the application requirements with the applicant;
- Refer to the detailed instructions in the packet for gathering documentation;
- Be available to assist when questions arise; and
- Be knowledgeable of:
 - Terminology;
 - Eligibility requirements; and
 - Processes explained throughout this manual to assist the applicant.

APPLICATION REQUIREMENTS

The individual or responsible parent is the applicant and will complete the NBS Benefits application. The applicant will provide the required details and supporting documentation.

Failure to provide all required information will result in a delay of review or a denial of eligibility.

One application must be completed for each family member being screened for eligibility (i.e., twins).

The individual over 18 years of age (if able) or parent/guardian/representative is required to sign and date the application.

Contractors should make applicants aware that a benefits determination can be delayed because:

- The application is incomplete;
- There are blank fields;
- The forms are missing signatures; or
- Required documentation is missing or too old.

The client will be responsible for obtaining the prescribed treatment from an enrolled pharmacy or medical foods provider for the duration of approved eligibility. If services are not provided, inadequate, or need to be changed, the client should consult with the contracted provider.

Family Composition – Determining the Household Size

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

For a child to be counted as part of the household, the child must be under 18 years of age and unmarried. A child will be considered a separate household of one at the end of the month the child becomes 18 unless the child is:

- A full-time student (as defined by the school) in high school, attends an accredited GED class, or regularly attends vocational or technical training as an equivalent to high school attendance; and
- Expected to graduate before or during the month of his/her 19th birthday.

If the child/applicant does not live with the natural parents, documentation is required to demonstrate the relationship between the caretaker and the child (i.e., guardianship, adoption, foster care, etc.).

A child in foster care placement will be considered a household of one.

Documentation of Family Composition

If a familial relationship is not established, use any of the following documentation to explain:

- Birth certificate;
- Baptismal certificate;
- School records;
- Adoption records;
- Foster care placement documents; or
- Other documents that the provider deems valid to establish the dependency of the family member upon the applicant or head of household.

Residency

To be eligible for NBS Benefits, an individual must:

- Be physically present within the geographic boundaries of Texas; and
- Have intent to remain within the state, whether permanently or for an indefinite period (Signing the Rights and Responsibility Form provides declaration of the intent to remain in the state); and not claim residency in any other state or country.

Note: If less than 18 years of age, his/her parent, managing conservator, or guardian must be a resident of Texas.

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

- Persons who move into the state solely for the purpose of obtaining health care services;
- Students who are primarily supported by their parents that reside in another state.

Individuals described below are not eligible to receive NBS Benefits:

- Inmates of correctional facilities;
- Residents of state schools;
- Patients in state psychiatric hospitals.

Documentation of Residency

For documentation of residency, **one** of the following items must be provided:

- Valid Texas driver license;
- Current voter registration;
- Rent or utility receipts for one month prior to the month of application;
- Motor vehicle registration;
- School records;
- Medical cards or other similar benefit cards;
- Property tax receipt;

- Mail addressed to the applicant, his/her spouse, or children if they live together; or
- Other documents considered valid by the provider.

Temporary Absences from State

Individuals do not lose their residency status because of temporary absences from the state. For example, a migrant or seasonal worker may travel during certain times of the year but maintains a home in Texas and returns to that home after these temporary absences. If a family is otherwise eligible, but residency is in question/dispute, the applicant is entitled to services until factual information regarding residency change proves otherwise.

Client's Responsibility for Reporting Changes

A client must report changes in the following areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of and/or other third-party coverage benefits. The client may report changes by mail, telephone, in-person, or through someone acting on the individual's behalf. Changes must be reported no later than 30 days after the client is aware of the change. If changes result in the client no longer meeting eligibility criteria, the individual will be denied continued services. By signing the required forms, the individual attests to the truth of the information provided.

Income

To be eligible for NBS Benefits, applicants must have a gross family income at or below 350% Federal Poverty Level (FPL).

Income used to determine eligibility is the combined gross income of all persons that are legally obligated to support the child and reside in the household.

If adoptive parents claim the child on their Tax Return they are considered legally obligated since they provide food, shelter, education and medical care for the child.

The table below details sources of earned and unearned income that contribute to the calculation of gross family income as well as income that is exempt or does not have to be counted.

Types of Income	Countable	Exempt
Adoption Payments		X
Cash Gifts and Contributions	X	
Child Support Payments	X	
Child's Earned Income		X
Crime Victim's Compensation		X
Disability Insurance Benefits	X	
Dividends, Interest, and Royalties	X	
Educational Assistance		X
Energy Assistance		X
Foster Care Payments		X
In-kind Income		X
Job Training		X
Loans (Non-educational)	X	
Lump-Sum Payments	X	X
Military Pay	X	
Mineral Rights	X	
Pensions and Annuities	X	
Reimbursements	X	
RSDI/Social Security Payments	X	
Self-Employment Income	X	
Social Security Disability Insurance (SSDI)	X	
Supplemental Security Income (SSI) Payments		X
Temporary Assistance for Needy Families (TANF)		X
Unemployment Compensation	X	
Veterans Administration (VA) Payments	X	X
Wages and Salaries, Commissions	X	
Worker's Compensation	X	

Definitions of Countable and Exempt Income

Cash Gifts and Contributions – *Countable* (Exemption: cash gifts and contributions made by a private, non-profit organization on the basis of need and total \$300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January–March, April–June, July–September, and October–December. If these contributions exceed \$300 in a quarter, count the excess amount as income in the month received).

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a noncertified household member who:

- Lives in the home with the certified household member;
- Shares household expenses with the certified household member; and
- No landlord/tenant relationship exists.

Child Support Payments – *Count* income after deducting \$75 from the total monthly child support payments the household receives.

Disability Insurance Payments/Social Security Disability Insurance (SSDI) *Countable*. SSDI is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest, and Royalties – *Countable*. Count royalties, minus any amount deducted for production expenses and severance taxes (Exception: Exempt dividends from insurance policies as income).

In-Kind Income – *Exempt*. An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational) – *Count* as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – *Count* as income in the month received if the person receives it or expects to receive it more than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – *Count* all military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – *Count* payments received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc.

Pensions and Annuities – *Countable*. A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – *Countable*, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

Retirement, Survivors, and Disability Insurance (RSDI)/Social Security Payments – *Count* the RSDI benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income – *Count* the total gross earned, minus the allowable costs of producing the self-employment income.

Supplemental Security Income (SSI) Payments – *Exempt*.

Terminated Employment – *Count* terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments – *Count* the gross benefit less any amount being recouped for an overpayment.

Veterans Administration (VA) Payments – *Count* the gross VA payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – *Count* the actual gross amount.

Worker's Compensation – *Count* the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. **Note: The Texas Department of Insurance or a court sets the amount of the attorney's fee to be paid.**

INCOME DETERMINATION

Count all income already received and any income the family expects to receive in one month. When an individual has not received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented on the application.

Count terminated income in the month received. Use actual income and **do not use [conversion factors](#) if terminated income is less than a full month's income.**

Use at least four consecutive, current pay periods to calculate projected monthly income. If an individual is paid one time per month and receives the same gross pay each month, then verification of one month pay period is acceptable.

Conversion Factor

If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- Weekly – multiply by 4.33
- Every two weeks – multiply by 2.17
- Twice a month – multiply by 2.0

Allowable Income Deductions

Dependent childcare or adult with disabilities care expenses must be deducted from total income in determining eligibility, if paying for the care is necessary for the employment of a member of the household. Allowable deductions are actual expenses up to:

- \$200 per month per child under age 2;
- \$175 per month per child age 2 or older; and
- \$175 per month for each adult with disabilities

Legally obligated child support payments made by a member of the household group must also be deducted. Payments made weekly, every two weeks, or twice a month must be converted to a monthly amount by using one of the above listed conversion factors.

Self-Employment Income (If an applicant earns self-employment income, it must be added to any income received from other sources.):

- Self-employment income should be reported on the Statement of Self-Employment Income form. The attached instructions for completing the form are detailed for required information.
- Annualize self-employment income that is intended for an individual or family's annual support, regardless of how frequently the income is received.
- If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.
- If the individual has had self-employment income for the past year, use the income figures from the previous year's business records or tax forms.
- If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.
- If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.
- If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date.
- A signed statement from individuals who are self-employed and have no documentation of their income will be accepted for a period of six (6) months. NBS Benefits coverage cannot be extended on subsequent applications without formal documentation of self-employment income.

Seasonal Employment – Include the total income for the months worked in the overall calculation of income. The total gross income for the year can be verified by a letter from the individual's employer, if possible.

Employment Terminated/New Employment – When the individual has been terminated, resigned, or laid off, the income from that job will then be disregarded. When an individual has not yet received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the provider on the application.

Disability – The individual must submit a statement from his/her physician verifying the approximate length of disability or a letter from the company/program providing eligibility dates.

Statements of Support – Unless the person providing the support to the individual is present during the interview and has acceptable documentation of identity, a statement of support will be required. The Statement of Support is used to document income when no supporting documentation is available or when income is irregular. If questionable, the provider may document proof of identification such as a Texas driver's license, Social Security card, or a birth certificate of the supporter.

If all attempts to document income are unsuccessful because the employer/payer fails or refuses to provide information or threatens continued employment, and no

other proof can be found, the provider may determine an amount to use on the form based on the best available information and document the determined income on the application.

Exclusions

NBS Benefits 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 eligibility determination.

Documentation of Income

Documentation of income must be provided to complete the application. Declarations of "unknown" will not be accepted as representations of required facts and documentation. To document income, the following documentation must be provided for at least four (4) consecutive current pay periods or one month's pay unless special circumstances are noted on the application:

- Document of income must be current and received in NBS Benefits within 60 days;
- Copies of the most recent paychecks;
- Copies of the most recent paycheck stubs/monthly earning statements;
- Employer's written verification of gross monthly income or the Employment Verification Forms (Release of Information and Employer's Verification);
- Award letters;
- Domestic relation printouts of child support payments;
- Letter of support;
- Unemployment benefits statement or letter from the Texas Workforce Commission;
- Award letters, court orders, or public decrees to verify support payments;
- Notes for cash contributions; or
- Other documents or proof of income determined valid by the provider.

NBS BENEFITS REVIEW OF ELIGIBILITY

When a complete application is received, NBS Benefits will:

- Review the Application, Prescription Request Form, Waiver of Ineligibility (if applicable) and the Statement of Applicant's Rights and Responsibilities for complete answers, signatures and supporting documents;
- Complete the review within 7 working days (2 working days for Immediate Medical Need cases) from the date the complete application was received;
- Notify contracted physician specialist when forms are incomplete or supporting documentation is missing;
- Verification of information may be necessary when there is contradictory or discrepant information and/or when information does not sufficiently explain the circumstances to support an eligibility decision. NBS Benefits shall allow the applicant an opportunity to resolve any discrepancy by providing documentary evidence or designating a suitable contact to verify information. If the applicant fails or refuses to do so, eligibility can be denied.

DATE OF ELIGIBILITY

After review and a determination is made, NBS Benefits will mail a notice to the applicant, coordinating provider and associate service providers.

- If eligible, the notice will state:
 - That services begin with the date on which NBS Benefits determines that the application is complete and approved;
 - The starting and ending dates of eligibility; and
 - The benefits and/or services the applicant is eligible to receive.
- If ineligible, the notice will state:
 - The reason the application was denied;
 - The effective date of denial;
 - The individual's right to appeal; and
 - If applicable, referral to alternative agencies/programs for services.

ANNUAL RENEWAL

Eligibility for NBS Benefits is valid for 12 months or one year, unless otherwise specified (See [Self Employment Income](#)). At least 30 days prior to the anniversary of their original eligibility date, NBS Benefits clients will be notified that they must renew eligibility by their anniversary date or may lose their benefits.

The client must submit a new Application to be re-evaluated for eligibility by the contractor and NBS Benefits annually. The client should update and/or verify information regarding family composition, residency, income, and should sign a new Statement of Applicant's Rights and Responsibilities.

All renewal documentation must be received at NBS Benefits within 60 days from the oldest document.

During the renewal process, the contractor should assist clients who request help in completing forms or providing documentation. The contractor will retain the original signed forms and supporting documentation in the client's record. NBS Benefits will notify the contractor and client of the eligibility determination.

APPEAL OF ELIGIBILITY DETERMINATION/DENIAL

If an applicant has been determined ineligible for NBS Benefits, the individual may appeal to the Newborn Screening Unit. Individuals may appeal the decision to deny services by submitting a written request for a hearing within 20 days after receipt of the denial notice. This notice is deemed received five days after the date of the notice. Appeals and requests for hearings can be faxed to (512) 776-7593, or mailed to:

Newborn Screening Unit
Department of State Health Services
Mail Code 1918
P.O. Box 149347
Austin, Texas 78714-9347

Or hand delivered to:

1100 West 49th Street
Mail Code 1918
Austin, TX 78756

If a request for a hearing is not received in the Newborn Screening Unit within 20 days after receipt of the denial notice, the decision is final.

MANDATORY DOCUMENTATION FOR CONTRACTORS

Contractors must have a case record for each client on file with originals of the following documentation:

- The eligibility or denial letters from other programs (where applicable);
- The completed and signed NBS Benefits application;
- A copy of the eligibility determination letter from the NBS Benefits staff;
- All prescription request forms for treatment and services;
- Acceptable documentation establishing family composition, residency and income;
- The signed Statement of Applicant's Right and Responsibilities; and
- Documentation of reported changes in the client's family composition, residency or income and its impact on eligibility, when applicable.

Records Retention

The contractor is responsible for maintaining client records per the record retention contractual requirements. NBS Benefits will maintain records documenting eligibility for four (4) 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.

All contracting agencies must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy. Information about HIPAA can be found at:

<http://www.hhs.gov/ocr/hipaa/>

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.texas.gov/contracts/cfpm.shtm>.

SECTION III: ALLOWABLE NBS BENEFITS

ALLOWABLE BENEFITS

NBS Benefits contractors shall provide or assure the provision of the following benefits to eligible clients:

- Confirmatory testing – Laboratory Procedures;
- Follow-up care – evaluation, office visits and/or consultations;
- Medical Management Services – prescribed medication, medical foods, vitamins and dietary supplements.

The lists of approved Laboratory Procedures and Medical Management Services for eligible clients are maintained and updated separately from this manual and posted on the NBS website. Click on the links to access the most up to date information.

Medical management also includes evaluations by contracted providers. 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

Codes **99201** through **99205** when billing for the evaluation and management of a new patient and services provided in the office, or in an outpatient or other ambulatory facility.

Established Patient Office Visit

Codes **99211** through **99215** when billing for established patient services provided in the office, or in an outpatient or other ambulatory facility.

New or Established Patient Office Consultation

Codes **99241** through **99245** when billing for new or established patient consultation provided in the office, or in an outpatient or other ambulatory facility.

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.

A specialist telephone consultation (procedure code **3-99499** with required 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).

Instructions for Documenting the Specialist Telephone Consultation

The specialist must maintain documentation in their records of any consultation regarding the client. The documentation must include the following information:

- Date of the phone consultation
- 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 this supporting documentation with a [State Purchase Voucher](#) for each client consultation provided per month ([Section IV: Billing](#)).

LOW PROTEIN FOODS (MEDICAL FOODS)

NBS Benefits may cover low protein foods for clients with an identified NBS disorder that prohibits them from eating a regular diet. Low protein foods are defined as:

- Lack the compounds which cause complications of the metabolic disorder;
- Are generally not available in grocery stores, health food stores, or pharmacies;
- Are not consumed as food by the general population;
- Are not covered under the Supplemental Nutrition Assistance Program (SNAP); and
- Products must be listed in enrolled providers' catalogs.

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

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

Low protein foods are reimbursable at wholesale cost plus 15%.

There is a limit of \$300.00 for low protein foods per client per month.

- NBS Benefits will mail:
 - The provider's catalog of foods to the client; and
 - The client's contact information to the medical foods provider.
- The client will obtain low protein foods directly from the provider; and
- The provider will bill NBS Benefits directly.

SECTION IV: BILLING

BILLING OVERVIEW

Contractors may only bill for the service(s) if:

- The client was screened for eligibility in other benefit programs.
- The client was determined to be ineligible for other programs or another funding source.
- The client is determined eligible for NBS Benefits.
- The items billed are on the approved lists or received approval from the NBS Medical Director prior to rendering services or dispensing medical management.

Reimbursements for:

- Physician services are set at Texas Medicaid rates (See [Section III](#) of this manual for allowable services).
- Laboratory Procedures and Services are set at established rates by contract.
- Medical Management Services of medical foods, dietary supplements and vitamins are reimbursable at wholesale cost plus 15%.

Contractors must submit documentation of wholesale price when billing for medical management services. Billing for shipping and handling will be reimbursed for any amount up to \$75.00 per order. The monthly limits per client are:

- \$1,500.00 for dietary supplements
- \$ 300.00 for vitamins
- \$ 300.00 for low protein foods
- Other limits may be assessed if the price of the item affects available funding for priority populations.

BILLING REQUIREMENTS

The **State of Texas Purchase Voucher** is submitted monthly, in aggregate, requesting reimbursement of allowable benefits at established rates. The voucher and [instructions](#) may be downloaded from:

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

The CMS-1500 Health Insurance Claim Form (Version 02/12) must be accurately filled out for each enrolled client who receives services during the payment month and be submitted to NBS Benefits with the Purchase Voucher. The Claim Form should be a consolidated list of all services the client received during the month. A sample CMS-1500 Claim Form and instructions are found on the Centers for Medicare and Medicaid Services websites at:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf>

Billing vouchers will not be processed for payment unless accompanied by corresponding CMS-1500 Forms for service(s) provided to enrolled clients. 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 2018 are due by March 31, 2018; invoices for March 2018 are due by April 30, 2018; invoices for April 2018 are due by May 31, 2018; and so on.

View a fact sheet about the CMS-1500 Forms: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf

Purchase vouchers must include the payee identification number and the current DSHS document number in order to be processed. Payments will be delayed if:

- The voucher does not include the required identification numbers, or the numbers are incorrect;
- The mathematical calculations are inaccurate;
- Payment is requested for unauthorized services; or
- More than one Claim Form is submitted for a client with the monthly payment voucher.

NON-REIMBURSABLE EXPENDITURES

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

- The individual is eligible for another program that would pay for all or part of the services in question (NBS Benefits does not reimburse any unpaid amount left by other benefit programs);
- The individual did not complete the eligibility process; or
- The contractor did not seek prior approval for an item or service not included or in excess of the limits for allowable benefits.

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 eligibility or denial. NBS Benefits may cover services delivered on the date the contracted provider determined the immediate medical need if the [presumptive eligibility determination process](#) was approved (duration is 60 days). **Once the client's denial letter from Medicaid and/or CHIP is received by NBS Benefits, the contractor may bill for the services provided on the initial day of service as well as subsequent services.**

If the individual is determined eligible to receive Medicaid, CHIP, or another funding source that covers the services, the contractor may not continue to bill NBS Benefits for services provided to the individual. The contractor should retroactively bill the funding source for the individual's initial visit, and credit the reimbursement to DSHS on the next purchase voucher submitted.

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.

APPENDIX A: State Resources

RESOURCE	WEB SITE AND CONTENTS	PHONE NUMBER
Local Community Resource Center Texas Health and Human Services Commission website with easy to find state and local health programs, resources and more.	http://www.211texas.org/ <ul style="list-style-type: none"> • Food / Nutrition • Housing • Childcare • Counseling, etc. 	2-1-1 1-877-541-7905
Children with Special Health Care Needs Services Program DSHS administered program that provides services to children under 21 who have extraordinary medical needs, disabilities, and chronic health conditions.	http://www.dshs.texas.gov/cshcn/ <ul style="list-style-type: none"> • Program description • Health benefits • Case management services • Family support services • Client application and forms • Provider manual and application 	1-512-776-7355
Client Services Contracting Unit (CSCU) DSHS web site for frequently asked contracting questions and a list of contact numbers for specific questions.	https://www.dshs.texas.gov/grants/ <ul style="list-style-type: none"> • Contracting questions and answers • State of Texas Purchase Voucher • Form #GC-10 (270) • Financial Administrative Procedures Manual • General provisions • Laws and regulations • Funding links 	1-512-776-7470
County Indigent Health Care Program (CIHCP) Program that provides health services to eligible residents through counties, hospital districts, and public hospitals in Texas.	http://www.dshs.texas.gov/cihcp/ <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Available services 	1-512-776-6467
Literature and Forms Inquiry & Order Entry System	https://www.dshs.texas.gov/newborn/pubs.shtm Instructions for ordering/downloading DSHS publications	1-512-776-3957
Genetic Services DSHS information and referral program. Oversees Title V genetic services program in the Fort Worth area.	http://www.dshs.texas.gov/genetics/ <ul style="list-style-type: none"> • Provider list by health service region • Genetics information and literature 	1-800-252-8023 ext. 3386
Newborn Screening (NBS) Texas newborns are required to be screened for certain disorders during the birth admission. DSHS maintains a NBS laboratory and provides case management services.	http://www.dshs.texas.gov/newborn/ <ul style="list-style-type: none"> • Screened disorders • Expansion information • Practitioner's guide • Specimen collection procedures • Available literature 	1-800-252-8023 ext. 3957
Primary Health Care Program DSHS administered program providing primary health care services to persons at or below 150% FPL who do not qualify for other health programs.	https://www.dshs.texas.gov/phc/default.shtm <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Services provided • Provider list by health service region 	1-512-776-2752
Quality Management Branch Assures that DSHS-funded contractors meet standards and requirements of the DSHS.	http://www.dshs.texas.gov/qmb/ <ul style="list-style-type: none"> • Policies, procedures, tools and instructions for on-site monitoring reviews • DSHS Standards for Public Health Clinic Services 	1-888-963-7111 ext. 6250
CHIP/Children's Medicaid Texas families with uninsured children may be able to get health insurance through Children's Medicaid and the Children's Health Insurance Program (CHIP).	https://chipmedicaid.org/ <ul style="list-style-type: none"> • Program descriptions • Income and eligibility criteria • Client application • Consumer guide to better health 	1-877-543-7669
Title V Maternal & Child Health Fee-for-Service Provides prenatal care, preventive and primary child care, case management for children from birth to one year and high risk pregnant women, as well as dental care for children and adolescents.	https://www.dshs.texas.gov/mch/fee/default.aspx <ul style="list-style-type: none"> • Program description • Income and eligibility criteria • Services provided • Provider list by health service region 	1-512-776-7373
Women, Infants and Children Program (WIC) Federal supplemental nutrition program administered by Texas Health and Human Services.	https://texaswic.org/ <ul style="list-style-type: none"> • Program description • Eligibility criteria • How to become a WIC client 	1-800-942-3678

APPENDIX B: Definitions

Below are definitions of terms or phrases that are used throughout this manual.

Annual Renewal – Process for renewing the client’s eligibility for NBS Benefits. Each year, one month before the anniversary date the client was deemed eligible for benefits, the client is prompted to reapply and be re-evaluated for NBS Benefits. To be considered eligible for another year of benefits, another application is required.

Applicant – Client – Patient –

- **Applicant** – the patient for which the application for NBS Benefits is being completed
- **Client** – an individual, who has been screened, has successfully completed the eligibility process and determined eligible for services.
- **Patient** – individual being treated for an illness by a physician or health care provider

Child and Adolescent – A person from his/her 1st birthday through the 21st year

Children with Special Health Care Needs Services Program – DSHS administered program that provides services to children under 21 who have extraordinary medical needs, disabilities, and chronic health conditions including cystic fibrosis.

Children’s Health Insurance Program (CHIP) Perinatal Program – A Health and Human Services Commission (HHSC) program that provides medical coverage for perinatal care of unborn children of non-Medicaid eligible women with an income up to 200% FPL.

Confirmatory testing – Diagnostic testing to confirm or clear an individual with a presumptive positive newborn screen.

Contractor – Any entity DSHS has contracted to provide NBS Benefits or services. The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

Consultation – A type of service provided by a physician with expertise in a medical specialty and, who upon request of another appropriate healthcare provider, assists with evaluation and/or management of a patient.

Diagnosis – A disorder that has been confirmed to be present in a patient based on clinical evaluation and additional testing including any of the following as necessary, laboratory testing (blood, urine or tissue tests), physiologic tests or radiologic exams.

Diagnostic Services – Laboratory studies or tests, x-rays and other appropriate services, ordered by the patient’s health care practitioner(s) to evaluate an individual’s health status for diagnostic purposes.

Dietary Supplement – A preparation intended to supplement the diet and provide nutrients, such as vitamins, minerals, fiber, fatty acids, or amino acids that may be missing or may not be consumed in sufficient quantities in a person's diet. Supplements are taken by mouth as a pill, capsule, tablet, or liquid and labeled on the front panel as being a dietary supplement.

Durable Medical Equipment (DME) – Medically necessary supplies or equipment capable of withstanding wear such as syringes, needles, and test strips. (NBS Benefits does not cover DME).

Eligibility Date – The effective date of client eligibility is the date NBS Benefits determines receipt of a complete application and approves the individual for benefits. NBS Benefits determines the date of eligibility ([TAC §37.62\(g\)](#)). The eligibility expiration date will be twelve months from the eligibility date.

Family Composition – A person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, who reside together and who are legally responsible for the support of the other person.

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

Immediate Medical Need – Documented statement from a physician that the patient's condition requires immediate treatment or services and the patient is unable to endure the delay of the application process before receiving approved benefits.

Laboratory, X-Ray, or other Appropriate Diagnostic Services – Studies or tests ordered by the patient's health care practitioner(s) to evaluate an individual's health status for diagnostic purposes.

Low Protein Foods (Medical Foods) – Modified foods which are low in protein.

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Medical Foods (Formula) – A food which is formulated to be consumed or by enteral administration under the supervision of a physician and which is intended for the specific dietary management of a disease or condition.

Medical Management Services – Services include prescriptions for medications, medical foods (low protein foods and formulas), dietary supplements, and vitamins that are deemed necessary for the treatment and management of the diagnosed disorder.

Medications – A substance or preparation used in treating disease. Medications can be used for maintenance of health and the prevention, alleviation, or cure of disease.

Minor – A person who has not reached his/her 18th birthday and who has not had the classification of minor removed in court or who is not or never has been married or recognized as an adult by the State of Texas.

Nutritional Services – Services that identify the nutritional status of an individual, and instruction which included appropriate dietary information based on the patient's needs, i.e. age, sex, health status, culture. This may be provided on an individual, one-to-one basis, or to a group of individuals.

Prescription Drugs – Medically necessary pharmaceuticals needed for the treatment of a diagnosed condition.

Presumptive Eligibility – Immediate short-term availability and access to health care services up to 60 days. An immediate medical need must exist and is determined by a contracted physician specialist.

Priority Population – Low income, uninsured or underinsured persons enrolled in NBS Benefits. Dependent on funding availability, benefits will be provided in the following priority 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)

Provider – A clinician or group of clinicians, who provide services including health care providers, physicians, dietitians, pharmacies, etc.

Referral Agency – An agency that will provide a service for NBS Benefits client that NBS Benefits contractor does not provide and it is not a reimbursable NBS Benefits service.

State Fiscal Year – September 1 - August 31.

Texas Resident – A person who resides within the geographic boundaries of the state of Texas.

Treatment – Any specific procedure used for management of a disease or pathological condition.

Vitamins – An organic compound and a vital nutrient that a person requires in limited amounts and is usually available in a person's diet.