TITLE V GENETIC MONITORING INSTRUCTIONS
FY 2007

Reviews are based on requirements found in the Genetic Services Procedures Manual. These instructions highlight review procedures. Please note that the manual should always be referred to as the complete reference.

REVIEW CRITERIA	INSTRUCTIONS
I. ELIGIBILITY	• The agency's Title V eligibility policy and procedures are reviewed. • Ten (10) patient records are reviewed. If the agency provides services at several sites, 10 records with a sampling from all genetic services provided are reviewed at each site visited. When possible, three (3) of the records should be of clients who have been or are currently on presumptive eligibility. • The reviewer selects the records to be reviewed from the provider's monthly billing logs over a period of several months. If a selected record is not available, the reviewer selects another record for review, and makes note of a finding related to the unavailability of records at the end of the tool in the "Other pertinent information as noted by reviewer" section. • Each component of the record review criteria is reviewed individually for compliance with that component. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is not in compliance. **Note: The following exceptions are automatic findings: (1) an eligibility finding resulting in the client's actual ineligibility; (2) overcharging the client for covered services; and (3) billing for services not documented in the client's record.**
1. The agency has written policy and procedures for determining Title V eligibility.	• The reviewer examines the agency's policy and procedures outlining the Title V eligibility determination process for consistency with the Title V Genetic Services Procedures Manual. • The reviewer checks the agency's process for verifying family composition, residency, and income. If the agency waives proof of family composition, residency, and income, this must be reflected in the eligibility policy.
2. The agency is utilizing an approved screening and eligibility tool.	• The approved screening and eligibility tool is: Screening and Eligibility Determination Form for Medical Services Assistance. The agency may use its own screening and eligibility tool, provided it is approved by DSHS. • The reviewer checks each client record for a completed screening and eligibility

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	form that includes: client name, physical address, family composition, appropriate supporting documentation, or if the provider's policy allows, indication that the "option" was taken, denial letters from Medicaid or CHIP, if applicable, and client and agency staff signatures and dates. • The reviewer checks to see that "Presumptive Eligibility Forms," if used, are completed under appropriate circumstances, as detailed in the Title V Genetic Services Procedures Manual. • To receive a "Yes," 100% of the records reviewed contain a completed screening and eligibility tool. **Note: Eligibility for Title V must be determined at least every 12 months.**
3. A current Statement of Applicant's Rights and Responsibilities Form has been signed and dated by the client and agency staff.	• The reviewer checks each client record for a signed and dated Statement of Applicant's Rights and Responsibilities Form. Completion of this form also is required for presumptive eligibility. **Note: The form only needs to be re-signed and dated in the event of a two-year break in service.**
II. BILLING	• The same records reviewed for eligibility are reviewed for billing.
1. The agency maintains monthly billing logs of services billed to Title V.	• The reviewer checks the agency's monthly billing log for dates and types of services billed to Title V.
2. Billing is for allowable services, and dates and services match the Title V billing log.	• The reviewer compares service date documentation in each client record to verify that it matches the date and service listed in the Title V billing log.
3. Clients at or below 100% of FPL are not charged a co-payment for Title V services, as required by Federal law.	• Under Title V Federal Regulations, clients who are at or below 100% of FPL must not be charged a co-payment for Title V services. • The reviewer checks each client record, as applicable, to verify adherence to this policy.
4. If a co-payment is charged for clients between 101-185% of the FPL, it is consistently applied.	• If co-payments are charged, the reviewer requests that the agency provide its co-payment policy and method of tracking and reporting co-payments. • No more than 25% of the Medicaid approved reimbursement shall be charged to clients between 101-185% of the FPL. • The reviewer checks each client record, as applicable, to verify adherence to this policy.
5. If the agency charges co-payments, the agency has reported co-payments collected as program income on the appropriate monthly voucher.	• The reviewer checks the agency's method of tracking and reporting co-payments.

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III. CLINICAL RECORD REVIEW	• Each component of the record review criteria is reviewed individually for compliance. To receive a "Yes," at least 80% of the records reviewed are in compliance with that component. That is, of 10 records reviewed, 8 (or 80%) must receive a "Yes" on that component. If a contractor/provider is out of compliance with a component, the "No" is marked with an explanation of which component is out of compliance. • The same records used for the eligibility and billing portions of the review may be used, and additional records selected as needed to ensure all components are reviewed. If multiple sites are visited during a review, ten (10) records from each site visited are reviewed.
1. Consent forms are completed and signed.	• The reviewer checks each client record for a signed General Consent for treatment form. This is scored on the Core Tool. • Consent for specific procedures (skin biopsy; amniocentesis) are included in each client record, as applicable.
2. Letters are sent to referral sources.	• The reviewer checks each client record for a copy of a letter summarizing findings of the client visit sent to the referring provider.
3. Family Genetic Health History (detailed or update as appropriate) is completed.	• Family Genetic Health History is a component of procedure codes 99245-TG, 99244-TG, 99214-TG, and 99404-TG. • The reviewer checks to see that the client record contains the following information for a <u>detailed</u> family genetic health history: 1. Reason for visit 2. Review of systems 3. Health and family history covering four matriarchal and patriarchal generations, including affected individuals in immediate and extended family 4. Family pedigree 5. Information on pregnancy, including prenatal/birth history/neonatal history 6. Developmental history 7. Educational history 8. Social history, including family dynamics, behavioral issues, and social interactions • The family genetic health history <u>update</u> is intended to update the detailed family genetic health history, and should include: 1. Client/parent concerns 2. Review of systems 3. Changes in the health of the client (e.g., loss of eyesight or change in muscle control) whether related to the genetic diagnosis or not.

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	4. Genetic related problems identified in newborns and other family members
4. Medical Genetics Physical Exam (complex, comprehensive, standard as appropriate) is completed.	• Medical Genetics Physical Exam is a component of procedure codes 99245-TG, 99244-TG, and 99214-TG. • The physical exam varies according to the specific needs of the client. Complex and comprehensive exams include items 1, 2 and 3 below. Standard exams are appropriate for follow-up, and generally do not include item number 1. • The reviewer checks to see that the client record contains documentation of: 1. Extensive anthropomorphic measurements, such as occipital frontal circumference, height, weight, measurement of inner and outer canthal distances, measurement of ear size and placement on the head, measurement of philtrum length, measurement of internipple distance, and measurement of finger and palm lengths. 2. Physical examination of the head, eyes, nose, mouth, oral pharynx, ears, neck, including assessment of thyroid gland size, chest, including breasts and heart, abdomen, including assessment of organ size and assessment for abnormal masses, genitalia-may include measurement of size of genital components, back, extremities, including measurement of any joint limitation, skin for abnormalities-may include Woods light exam for fluorescent depigmented areas, and neurological assessment. 3. Photographs of the client, AP and lateral, both face and total body, and additional photographs of any abnormalities noted upon physical exam.
5. Appropriate laboratory and diagnostic tests are ordered, documented, reviewed by appropriate staff, and acted upon.	• Allowable genetic diagnostic and laboratory procedures include those published in the genetic services section of the Texas Medicaid Provider Procedures Manual. • Indication(s) for tests must be documented in the client's medical record. • Genetic ultrasound testing may not be used as a substitute for routine obstetric ultrasounds. Genetic ultrasound testing is provided for the following indications, which must be documented in the client's record: 1. History of previous child with birth defect(s) 2. Increased risk for child with genetic problem as ascertained by family history 3. Abnormal triple screen 4. Abnormal routine obstetric ultrasound • Genetic service providers should not order maternal triple screens for those clients referred by a Title V MCH provider. The triple screen should be ordered by the Title V MCH provider and sent to the DSHS lab or paid for with non-contract funds. Genetic service providers may not bill DSHS for triple screens for clients referred by Title V MCH providers.

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	• The reviewer checks to see that each client record contains documentation that diagnostic or lab test(s) were ordered and the indication(s) for the test(s), results reviewed, and client notified of results.
6. Psychosocial Genetic Assessment is completed.	• Psychosocial Genetic Assessment is a component of procedure codes 99245-TG and 99244-TG. • The reviewer checks the client record for a detailed social history to assess family dynamics and psychosocial functioning.
7. Medical Genetic Counseling and Psychosocial Genetic Counseling is completed.	• Medical Genetic Counseling and Psychosocial Genetic Counseling are components of procedure codes 99215-TG and 99213-TG. • The reviewer checks each client record for documentation of: 1. Review of health history and family genetic history or pedigree construction. 2. Normal/abnormal findings and diagnosis discussed. 3. Implications for affected individual, immediate family, and extended family; prognosis, recurrent risks, family planning implications, and options available to family members who are at increased risk for giving birth to a child with the same condition. 4. Client reaction to genetic disorder. 5. Appropriate plan of action, referrals, and follow-up. • Follow-up genetic counseling and psychosocial genetic counseling includes: review of previous medical and psychosocial genetic counseling and provision of additional information as indicated.
8. Prenatal Counseling is completed.	• The reviewer checks each client records for documentation of: 1. Pregnancy history, including use of medications, alcohol, cigarettes, street drugs, vitamins/ 2. Detailed family history, including genetic history and pedigree construction/ 3. Lab test reports/ 4. Counseling on prenatal diagnosis, recurrence risks, prenatal diagnostic procedures. 5. Appropriate plan of action, referrals, and follow-up.
Other pertinent information as noted by reviewer:	