

Texas Medicaid

Provider Procedures Manual

November 2026

Volume 2

Provider Handbooks

School Health and Related Services (SHARS) Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

SCHOOL HEALTH AND RELATED SERVICES (SHARS) HANDBOOK

Table of Contents

1 General Information 4

2 School Health and Related Services (SHARS) 4

2.1 Overview 4

2.1.1 Eligibility Verification 7

2.2 Enrollment 7

2.2.1 School Health and Related Services Enrollment 7

2.2.2 Private School Enrollment 8

2.3 Services, Benefits, Limitations, and Prior Authorization 8

2.3.1 Audiology Services 8

2.3.2 Nursing Services 11

2.3.3 Occupational Therapy (OT) Services 13

2.3.4 Personal Care Services 15

2.3.4.1 PCS Provider Requirements 15

2.3.4.2 Activities Eligible for PCS 16

2.3.5 Physical Therapy (PT) Services 19

2.3.6 Physician Services 21

2.3.7 Psychological Services and Counseling 22

2.3.7.1 Psychological Testing 22

2.3.7.2 Counseling Services 23

2.3.7.3 Psychological Services 25

2.3.8 Special Transportation Services 26

2.3.8.1 Documentation for Special Transportation Services 27

2.3.9 Speech and Language Services 28

2.3.9.1 Supervision Requirements for SLPs 29

2.3.10 Telehealth and Telemedicine Services 30

2.3.10.1 Telehealth Services 31

2.3.10.2 Telemedicine Services 34

2.3.11 Prior Authorization 36

2.4 Documentation Requirements 36

2.4.1 Record Retention 38

2.5 Managed Care Clients 38

2.6 Third Party Liability 39

2.7 Claims Filing and Reimbursement 39

2.7.1 Claims Information 39

2.7.1.1 Appealing Denied SHARS Claims 39

2.7.2 Reimbursement Guidelines: Cost Reporting and Interim Claims 39

2.7.2.1 Interim Claiming 39

2.7.2.2 Cost Reporting 41

2.7.2.3 Cost Reconciliation and Cost Settlement 42

2.7.2.4 *Informal Review of Cost Reports Settlement 42

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

2.7.2.5 Quarterly Certification of Funds 43
2.8 * Random Moment Time Study (RMTS) 43

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

1 General Information

The information in this handbook is intended for school districts and healthcare providers who provide school-based health services for children aged 20 years and younger. This handbook contains information about Texas Medicaid benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

All providers are required to report suspected child abuse or neglect as outlined in subsection 1.7, "Provider Responsibilities" in "Section 1: Provider Enrollment and Responsibilities" (Vol. 1, General Information).

2 School Health and Related Services (SHARS)

2.1 Overview

SHARS are direct medical services and transportation services available to children who are 20 years of age or younger, enrolled in Medicaid and are eligible to receive services under the Individuals with Disabilities Education Act (IDEA). The services must be included in the child's individualized education program (IEP) established under IDEA.

SHARS also includes audiology evaluation and management services provided to eligible students under Section 504 of the Rehabilitation Act of 1973. The services must be included in the child's written Section 504 Plan.

Local Education Agencies (LEAs), which include Texas independent school districts (ISDs) and public charter schools, must enroll in Texas Medicaid as a SHARS provider to be reimbursed for providing direct medical and transportation services to Medicaid enrolled students in a school setting.

The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and the Texas Health and Human Services Commission (HHSC).

According to Title 34 Code of Federal Regulations (CFR) §300.303, re-evaluations for SHARS services must occur at least once every 3 years, unless the parent and the public agency agree that a re-evaluation is unnecessary.

SHARS allows LEAs to be reimbursed for direct medical and transportation services that are determined to be medically necessary and are documented in the IEP.

The Centers for Medicare & Medicaid Services (CMS) require LEAs to be enrolled as SHARS Medicaid providers, participate in the Random Moment Time Study (RMTS), submit claims that are reimbursed on an interim basis, and submit an annual SHARS Cost Report.

To receive SHARS services, Medicaid-enrolled students must:

- Be enrolled in a public school's special education program; and

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- Be 20 years of age or younger; and
- Have a disability or chronic medical condition; and
- Have an IEP documenting disability and medical necessity; or
  - An IEP is a written plan mandated by IDEA that is developed by the school, in conjunction with the parents or guardians, teachers and other health professionals. This plan authorizes the services that can be provided and defines the individualized objectives of a child who has been found to have a disability.
  - The IEP is created by an ARD (Admission, Review, and Dismissal) Committee.
  - Title 34 CFR §300.320 outlines what must be included in an IEP.
  - The SHARS program cannot reimburse for services beyond what is detailed in the IEP.
- Have a written Section 504 plan, documenting disability and medical necessity for audiology evaluation and management services.
  - A Section 504 plan is a plan mandated by 29 United States Code (U.S.C.) Section 794, regulated by 34 CFR §104, and developed by the school, in conjunction with the parents or guardians, teachers, and school administration. The plan must include evaluation data along with placement information regarding the type of services the student needs.
  - Evaluation under a Section 504 plan may be conducted using the same process to evaluate the needs of students under IDEA. In accordance with 34 CFR §104.35, LEAs may choose to adopt a separate process for evaluating students under a Section 504 plan.
  - The SHARS program cannot reimburse for services under a Section 504 plan beyond audiology evaluation and management services.

SHARS covers the following services:

- Audiology, delivered by licensed audiologist
- Counseling, individual and group, delivered by licensed master's level therapist
- Nursing services, including medication administration and nursing services delegated by a registered nurse (RN) (in compliance with RN delegated nursing tasks criteria as determined by the Texas Board of Nursing) to an employee or health aide
- Occupational therapy (OT), individual and group, delivered by licensed therapist or licensed assistant
- Personal care services (PCS)
- Physician services
- Physical therapy (PT), individual and group, delivered by licensed therapist or licensed assistant
- Psychological services, individual and group, delivered by a licensed psychiatrist/psychologist or a licensed specialist in school psychology (LSSP)
- Special transportation services
- Speech therapy (ST), individual and group, delivered by licensed therapist or licensed assistant

Note: *These services must be provided by qualified personnel who are employed by the LEA or under contract with the LEA.*

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Subject to the specifications, conditions, limitations, and requirements established by HHSC, SHARS are the services outlined above and determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age or younger receive the benefits accorded to them by federal and state law guaranteeing a free and appropriate public education.

Care coordination between SHARS OT, PT, and ST providers and non-SHARS OT, PT, and ST providers is strongly encouraged to reduce or avoid duplication of services. Care coordination requires parental consent and must be carried out in a manner that complies with privacy and confidentiality requirements in accordance with state and federal law and regulations including Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA).

Multi-disciplinary team evaluations performed collaboratively with any combination of OT, PT, ST, and Psychology are billable by each provider when performed during overlapping time periods.

Reimbursement is available for OT, PT, or ST prescribed on the student's IEP when delivered as co-treatment. Providers should document in the session notes the reason for co-treatment.

Co-treatment is defined as two different therapy disciplines performing therapy on the same client at the same time by a licensed therapist as defined in this handbook for each therapy discipline and rendered in accordance with the Executive Council of Physical Therapy and Occupational Therapy Examiners (ECPTOTE) and Texas Department of Licensing and Regulation (TDLR).

Providers of SHARS services must meet Texas Medicaid provider qualifications for each service according to the Texas Medicaid state plan and the Texas Medicaid Provider Procedures Manual (TMPPM).

All SHARS policies must be consistent with the Texas state plan and the following Texas Administrative Code rules:

- 1 TAC §354.1341 & §354.1342 SHARS
- 1 TAC §354.1003(a)(5)(J) Time Limits for Submitted Claims
- 1 TAC §355.8441(a)(12)(A) Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- 1 TAC §355.8443 Reimbursement Methodology for SHARS
- 1 TAC §355.101 - §355.114 Cost Determination Process

In accordance with 34 CFR §300.154, 1 TAC §354.1342, and FERPA, LEAs are required to obtain parental consent prior to disclosing personally identifiable student information maintained in a student's education record, and are also required to obtain parental consent for Medicaid-enrolled students prior to billing Medicaid for SHARS services prescribed in the Medicaid-enrolled student's IEP or Section 504 plan.

Providers must adhere to the documentation requirements for each SHARS service outlined in this handbook.

SHARS services may be provided in the following places of service: office, home, or other location (e.g., school).

A prescription is defined as a written order for services from the ordering physician or other eligible prescribing provider. Prescriptions are required for SHARS OT and PT services.

Other eligible prescribing provider is defined as an advanced practice registered nurse (APRN) under the delegation of a physician, or a physician assistant (PA) under the delegation of a physician.

Referrals are required for SHARS audiology and speech therapy (ST) services.

Note: *A prescription may serve as a referral.*

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

A referral is defined as a written document requesting evaluation for services from the referring physician or other eligible referring provider, defined as follows:

- For SHARS audiology - an audiologist referring for audiology services, an APRN under the delegation of a physician, or a PA under the delegation of a physician
- For SHARS ST services - a speech-language pathologist (SLP) with an unrestricted license to provide services independently referring for speech and language services, an APRN under the delegation of a physician, or a PA under the delegation of a physician

2.1.1 Eligibility Verification

The following are means to verify Medicaid eligibility of students:

- Verify electronically through third party software or TexMedConnect.
- School districts may inquire about the eligibility of a student by submitting the student's Medicaid number or two of the following: name, date of birth, or Social Security number (SSN). A search can be narrowed further by entering the county code or sex of the student. Verifications may be submitted in batches without limitations on the number of students.
- Contact AIS at 1-800-925-9126.

2.2 Enrollment

2.2.1 School Health and Related Services Enrollment

To enroll in Texas Medicaid as a SHARS provider, the provider must:

- Be an LEA school that employs or contracts with individuals or entities that meet health care practitioner certification and licensing requirements in accordance with the Texas Medicaid state plan for SHARS.
- Since LEAs are government entities, they should select "public entity" on the enrollment application.
- Comply with all applicable federal and state laws and regulations governing the services provided.
- Be enrolled and approved for Texas Medicaid participation.
- Sign a written provider agreement.
- Comply with the terms of the provider agreement and all requirements of Texas Medicaid, including the rules, policies and procedures, manuals, bulletins, banners, standards, and guidelines published by Texas Health and Human Services Commission (HHSC) or its designee.
- Bill for services covered by Texas Medicaid in the manner and format prescribed by HHSC or its designee.

SHARS providers are required to notify parents or guardians of their rights to a "freedom of choice of providers" (42 CFR §431.51) under Texas Medicaid. SHARS providers may provide this notification during the initial Admission, Review, and Dismissal (ARD) process. If a parent requests that someone other than the employees or currently contracted staff of the SHARS provider LEA provide a required SHARS service listed in the student's IEP, the SHARS provider must make a good faith effort to comply with the parent's request. The SHARS provider can negotiate with the requested provider to provide the services under contract. The requested provider must meet, comply with, and provide all of the employment criteria and documentation that the SHARS provider normally requires of its employees and currently contracted staff. The SHARS provider can negotiate the contracted fee with the requested provider and is not required to pay the same fee that the requested provider might receive from Medicaid for similar services.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

If the requested provider is a currently enrolled Medicaid provider, the requested provider can bill Medicaid for the services they provide. The services provided to the student can only be billed once; either by the requested provider or the SHARS provider. If the requested provider signs a contract with the SHARS provider, then only the SHARS provider can bill for the services provided by the requested provider.

2.2.2 Private School Enrollment

A private school may not participate in the SHARS program as a SHARS provider.

2.3 Services, Benefits, Limitations, and Prior Authorization

All of the SHARS procedures listed in the following sections require a valid diagnosis code. SHARS includes audiology services, counseling services, nursing services, occupational therapy services, personal care services, physical therapy services, physician services, psychological services (including testing), special transportation services, and speech therapy services.

Reminder: *SHARS are the services determined by the ARD committee to be medically necessary and reasonable to ensure that children with disabilities who are eligible for Medicaid and who are 20 years of age and younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.*

2.3.1 Audiology Services

Audiology services include, but are not limited to, the following:

- Identification of children with hearing loss
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing
- Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversion
- Determination of the child's need for group and individual amplification
- Hearing services

Audiology services must be provided by a professional who holds a valid state license as an audiologist. An audiology assistant who is licensed by the state may provide services within the guidelines of state licensure when the assistant or intern is acting under the supervision of a qualified audiologist.

A referral is required for audiology services. The referral must be updated a minimum of one time every three calendar years.

The LEA must maintain the referral in the student's medical record.

Audiology services must be referred by a physician or other eligible referring provider. A referral for audiology services must be signed and dated within three calendar years before the initiation of services.

In order for audiology services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the referring licensed physician, or other eligible referring provider, must be listed on the claim and kept in the student's medical record.

Within SHARS, Medicaid-enrolled audiologists may refer for their own services or those of another SHARS audiologist. They may not refer for any services outside of SHARS or for SHARS services of other disciplines.

SHARS audiologists whose evaluations serve as the referral must be enrolled in Texas Medicaid as either individual practitioners or ordering, referring, or prescribing (ORP) providers. When submitting claims for SHARS audiology services, LEAs must include the referring provider's NPI in the referring provider NPI field of the claim form.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

IDEA requires that a student receiving services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee.

Only the time spent with the student present is billable; time spent without the student present is not billable. Direct audiology evaluation time with the student present is billable. Indirect time for interpretation and report writing is not billable.

Hearing aids and fittings are not covered by the SHARS program, but may be reimbursed through Texas Medicaid outside of the SHARS program. Audiologists and hearing aid fitters and dispensers employed by or contracted with school districts must enroll in Texas Medicaid as individual practitioners and choose "Hearing Aid" on the enrollment application to be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits.

Functional listening evaluations are not billable.

Audiometry is the testing of a person's ability to hear various sound frequencies and is performed with the use of calibrated electronic equipment. The results of the audiometry test may be recorded on a grid or graph called an audiogram. Audiometry is used to identify and diagnose hearing loss.

Audiology Services Procedure Codes

Procedure Code	Individual or Group	Provider	Student Population	Unit of Service
92552 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92552 with modifier U4	Individual	Licensed audiologist	504	Untimed
92553 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92553 with modifier U4	Individual	Licensed audiologist	504	Untimed
92555 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92555 with modifier U4	Individual	Licensed audiologist	504	Untimed
92556 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92556 with modifier U4	Individual	Licensed audiologist	504	Untimed
92557 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92557 with modifier U4	Individual	Licensed audiologist	504	Untimed
92567 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92567 with modifier U4	Individual	Licensed audiologist	504	Untimed
92568 with modifier TM	Individual	Licensed audiologist	IEP	Untimed

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Procedure Code	Individual or Group	Provider	Student Population	Unit of Service
92568 with modifier U4	Individual	Licensed audiologist	504	Untimed
92582 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92582 with modifier U4	Individual	Licensed audiologist	504	Untimed
92620 with modifier TM	Individual	Licensed audiologist	IEP	60 minutes
92620 with modifier U4	Individual	Licensed audiologist	504	60 minutes
92621 with modifier TM	Individual	Licensed audiologist	IEP	15 minutes
92621 with modifier U4	Individual	Licensed audiologist	504	15 minutes
92630 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92630 with modifier U4	Individual	Licensed audiologist	504	Untimed
92633 with modifier TM	Individual	Licensed audiologist	IEP	Untimed
92633 with modifier U4	Individual	Licensed audiologist	504	Untimed
92636 with modifier TM	Individual	Licensed audiologist	IEP	30 minutes
92636 with modifier U4	Individual	Licensed audiologist	504	30 minutes
92637 with modifier TM	Individual	Licensed audiologist	IEP	15 minutes
92637 with modifier U4	Individual	Licensed audiologist	504	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Audiology Services Modifiers

Modifier	Description
52	Reduced Services
TM	Audiology services provided to students with individualized education program (IEP)
U4	Audiology services provided to students with Section 504 plan

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Pure tone audiometry (procedure codes 92552 and 92553) is limited to one per day, any provider. If both procedure codes are billed for the same date of service, same provider, and same student, procedure code 92553 will be reimbursed and procedure code 92552 will be denied.

Speech audiometry threshold (procedure codes 92555 and 92556) is limited to one of either procedure code per day, any provider. If both procedure codes are billed for the same date of service, same provider, and same student, procedure code 92556 will be reimbursed and procedure code 92555 will be denied.

Comprehensive audiometry (procedure code 92557) is limited to one per day, same provider. This service includes testing of both ears. If procedure codes 92552, 92553, 92555, or 92556 are billed for the same date of service, same provider, and same student as procedure code 92557, only procedure code 92557 will be reimbursed.

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider for the same student. Instead of billing both procedure codes for the same date of service, same provider, and same student, providers should bill with the more appropriate, comprehensive audiometry procedure code 92557.

Tympanometry (procedure code 92567) is limited to one per day, any provider. Acoustic reflex testing, threshold (procedure code 92568) is limited to one per day, any provider.

Conditioning play audiometry (procedure code 92582) is limited to one per day, any provider.

The use of procedure codes 92552, 92553, 92555, 92556, 92557, 92567, 92568, and 92582 implies that testing is performed in both ears. Audiologists must use modifier 52, reduced services, if a test is applied to one ear instead of both.

Auditory processing evaluation (procedure codes 92620 and 92621) is billable on an individual basis only. The maximum billable time for the first hour of an auditory processing evaluation (procedure code 92620) is 60 minutes (1 unit). The maximum billable time for each additional 15 minutes of an auditory processing evaluation (procedure code 92621) is 60 minutes (4 units).

Auditory processing evaluation (procedure code 92620) is limited to one per day, any provider.

Auditory rehabilitative treatment (procedure codes 92630 and 92633) is limited to one per day, any provider. Session notes for therapy services (procedure codes 92630 and 92633) are required.

2.3.2 Nursing Services

Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the maintenance and restoration of health. SHARS nursing services are skilled nursing tasks, as defined by the Texas Board of Nursing (BON) that are included in the student's IEP.

Examples of reimbursable nursing services include, but are not limited to, the following:

- Inhalation therapy
- Ventilator monitoring
- Nonroutine medication administration
- Tracheostomy care
- Gastrostomy care
- Ileostomy care
- Catheterization
- Suctioning
- Client training

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- Assessment of a student's nursing service's needs

Nursing services must be provided by a registered nurse (RN), advanced practice registered nurse (APRN) (including nurse practitioners [NPs] and clinical nurse specialists [CNSs]), licensed vocational nurse/licensed practical nurse (LVN/LPN), or a school health aide or other trained, unlicensed assistive person delegated and supervised by an RN or APRN.

As defined by 22 TAC §225.4, nurse-delegated tasks are those in which a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. Nurse-delegated tasks includes tasks listed in 22 TAC §225.10 and must meet the professional standards of the Texas Board of Nursing.

Personal Care Services (PCS) cannot be billed as a nursing service. If a SHARS provider is not sure whether to bill a service as PCS or a nursing service, the SHARS provider must discuss the services provided to the student with the RN or APRN who can make that determination.

A prescription is not needed to provide nursing services through SHARS.

Only the time spent with the student present is billable. Time spent without the student present is not billable.

Private duty nursing (PDN) is not a SHARS covered service.

Providers of nursing services must follow the Texas BON guidelines for documenting the administration of medication.

Nursing Services Procedure Codes

Procedure Code	Individual or Group	Unit of Service
T1002 with modifier TD	Individual	15 minutes
T1002 with modifier TD and UD	Group	15 minutes
T1002 with modifier U7	Delegation, Individual	15 minutes
T1002 with modifier U7 and UD	Delegation, Group	15 minutes
T1003 with modifier TE	Individual	15 minutes
T1003 with modifier TE and UD	Group	15 minutes
T1502 with modifier TE	Unspecified	Medication, administration per visit
T1502 with modifier TD	Unspecified	Medication administration, per visit
T1502 with modifier U7	Unspecified	Delegation, medication administration, per visit

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

The following 15-minute procedure codes for direct nursing services are limited to 16 combined units (four hours) per day:

Procedure Codes					
T1002 with modifier TD	T1002 with modifier TD and UD	T1002 with modifier U7	T1002 with modifier U7 and UD	T1003 with modifier TE	T1003 with modifier TE and UD

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following procedure codes are limited to a total of four combined medication administration visits per day:

Procedure Codes		
T1502 with modifier TD	T1502 with modifier U7	T1502 with modifier TE

All of the nursing services minutes that are delivered to a student during a calendar day must be added together before they are converted to units of service.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day.

Direct nursing care services are billed in 15-minute increments and medication administration is reimbursed on a per-visit increment. The RN or APRN determines whether these services must be billed as direct nursing care or medication administration.

Nursing Services Modifiers

Modifier	Description
TD	Nursing services provided by an RN or APRN
TE	Nursing services delivered by an LVN/LPN
U7	Nursing services delivered through delegation
UD	Nursing services delivered on a group basis

2.3.3 Occupational Therapy (OT) Services

OT evaluation services include determining what services, assistive technology, and environmental modifications a student requires for participation in the special education program.

Occupational therapy services include the following:

- Improving, developing, maintaining, or restoring functions impaired or lost through illness, injury, or deprivation.
- Improving the ability to perform tasks for independent functioning when functions are impaired or lost.
- Preventing, through early intervention, initial or further impairment or loss of function.

Occupational therapy uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through an acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes.

ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

A prescription is required for OT services. The prescription must be updated a minimum of one time every three calendar years.

Occupational therapy services must be prescribed by a physician or other eligible prescribing provider. A prescription for OT services must be signed and dated within three calendar years before the initiation of services.

OT services may be reimbursed up to (but not to exceed) the amount designated in the prescription.

In order for OT services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the prescribing licensed physician, or other eligible prescribing provider, must be listed on the claim and kept in the student's medical record.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate prescription is not required for a re-evaluation.

The need for a re-evaluation should be determined by the student's ARD committee.

The LEA must maintain the prescription in the student's medical record.

Occupational therapy must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners to provide OT within his or her licensed scope of practice. An occupational therapist assistant (OTA) must act under the supervision of a qualified occupational therapist.

Services provided by an unlicensed person acting under the supervision of a licensed occupational therapist are not a benefit of Texas Medicaid.

OT treatment may be provided in an individual or group setting.

OT evaluation is billable on an individual basis only.

If an evaluation is performed over several days, the provider must submit the same evaluation procedure code for each evaluation session. The procedure code submitted must reflect the complexity level of the entire evaluation.

The therapist who performs the evaluation should use professional clinical judgment to decide which evaluation code to use. The selection of low (procedure code 97165), moderate (procedure code 97166), or high complexity (procedure code 97167) evaluation codes must be based on professional clinical judgment and may not be made by staff other than the rendering therapist.

The occupational therapist or OTA can only bill for time spent with the student present, including time spent assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time), report writing, and time spent manipulating or modifying the adaptive equipment is not billable.

Occupational Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
97150 with modifier GO	Group	Licensed occupational therapist	15 minutes
97150 with modifier GO and U1	Group	Licensed occupational therapy assistant	15 minutes
97165 (low), 97166 (moderate), and 97167 (high)	Individual	Licensed occupational therapist	15 minutes
97530 with modifier GO	Individual	Licensed occupational therapist	15 minutes
97530 with modifier GO and U1	Individual	Licensed occupational therapy assistant	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes for procedure codes 97530 and 97150 (therapy services) are required.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Providers must use a 15-minute unit of service for billing.

The following direct therapy procedure codes must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day:

Procedure Codes	
97150 with modifier GO	97530 with modifier GO
97150 with modifier GO and U1	97530 with modifier GO and U1

The maximum billable time for the following OT evaluation procedure codes is 12 units (three hours), which may be billed over several days within a 30-day period:

Procedure Codes		
97165	97166	97167

Occupational Therapy Modifiers

Modifier	Description
GO	OT therapy, individual/group, by licensed therapist
GO and U1	OT therapy, individual/group, by licensed/certified assistant

Note: *OT services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.4 Personal Care Services

Personal care services (PCS) are medical support services provided to students who require assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) because of a physical, functional, cognitive, or behavioral limitation related to a student's disability or chronic health condition.

PCS are medically necessary only when the student's physical, functional, cognitive, or behavioral limitation related to the student's disability or chronic health condition inhibits the student's ability to accomplish ADLs or IADLs.

PCS are not educational in nature and may not be reimbursed for activities that teach the student academic or functional skills.

2.3.4.1 PCS Provider Requirements

All PCS providers must:

- Be employed by or contracted with the local education agency (LEA).
- Meet the requirements of 42 CFR § 440.167.
- Have demonstrated the understanding and competence necessary to perform the eligible PCS tasks required by a student's IEP, including written documentation procedures.

PCS providers must understand and be competent to perform PCS in the following two competence areas:

- Appropriate techniques for assisting with ADLs and IADLs, including basic body mechanics, mobility, and techniques for transferring students.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- The needs of students with disabilities, including appropriate techniques for managing adverse behaviors of the student and communicating with students with communication or sensory impairments.

The LEA may use the following methods to determine whether an individual is qualified to perform PCS in the two competence areas:

- A review of the individual's education, related certification, or related training
- An evaluation from one or more qualified employees of the LEA verifying competence, which may additionally consider work experience, evaluations from other qualified employees of the LEA, and on-site demonstration.

The LEA may provide training to develop understanding and competence if the individual lacks understanding and competence in an area of PCS.

LEAs must document the PCS provider's ability to perform assistance generally with ADLs and IADLs for students enrolled in special education. In a centralized location, the LEA must keep a statement that is signed and dated by a qualified employee of the LEA, that the individual is able to perform PCS tasks under the direction of a qualified employee of the LEA.

For the purposes of verifying PCS provider qualifications, a qualified employee of the LEA is defined as:

- An individual with current special education teacher certification under 19 TAC §233.8 whose work responsibilities include working with PCS providers; or
- An individual whose primary work responsibilities include supervising, training, and confirming the qualifications of PCS providers; or
- A licensed health care practitioner eligible to provide reimbursable services under a SHARS benefit other than PCS.

A prescription is not needed to provide PCS through SHARS.

2.3.4.2 Activities Eligible for PCS

PCS facilitate the completion of ADLs and IADLs through direct intervention or indirect intervention, which includes but is not limited to the following:

- Hands-on assistance
- Performing the tasks for the student
- Cueing or redirecting the student to perform a task

PCS are not intended to teach the student how to independently perform the task.

For the purposes of reimbursement, activities eligible for personal care services are limited to the ADLs and IADLs listed in this section. ADLs are activities that are essential to daily self-care. IADLs are activities related to living independently in the community.

> ***Note:*** *Health Maintenance Activities (HMAs) and nurse-delegated tasks, as defined by 22 TAC §225.4, should be considered Nursing Services and may only be billed under PCS if the task is listed as an ADL or IADL.*

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

For the purposes of reimbursement, the activities that are eligible for PCS are limited to the following ADLs and IADLs. ADLs are activities that are essential to daily self-care. IADLs are activities related to living independently in the community.

ADLs	Description
Bathing	Assisting the student with any or all parts of bathing, including selecting appropriate water temperature and flow speed; turning water on and off; laying out and putting away supplies; transferring in and out of the bathtub or shower; washing and drying hair and body; and clean-up after task is completed
Dressing	Assisting the student with any or all parts of getting dressed, including putting on, fastening, and taking off all items of clothing; donning and removing shoes or prostheses; and choosing and laying out weather-appropriate clothing
Eating	Assisting the student with some or all parts of eating and drinking, including feeding the student; assistance with utensils or special or adaptive eating devices; and clean-up after task is completed.
Locomotion or mobility	Assisting the student with moving between locations, including assisting the student with walking or using a wheelchair, walker, or other mobility equipment
Personal hygiene	Assisting the student with some or all parts of personal hygiene, including routine hair care; oral care; ear care; shaving; applying makeup; managing feminine hygiene; washing and drying face, hands, and perineum; basic nail care; applying deodorant; routine skin care; and clean-up after task is completed
Positioning	Assisting the student with positioning their body while in a chair, bed, or other piece of furniture or equipment, including changing and adjusting positions; moving to or from a sitting position; turning side-to-side; and assisting the student to sit upright
Toileting	Assisting the student with some or all parts of toileting, including using a commode, bedpan, urinal, or toilet chair; transferring on and off; cleansing; changing diapers, pads, and incontinence supplies; adjusting clothing; and clean-up after task is completed
Transferring	Assisting the student with moving from one surface to another with or without a sliding board, including moving from a bed, chair, wheelchair, or vehicle to a new surface; moving to or from a standing or sitting position; and moving the student with lift devices

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

IADLs	Description
Escort	Assisting the student in making transportation arrangements for medical and other appointments; accompanying the student to a SHARS-eligible service or health care appointment on or off campus to assist with needed ADLs or with carrying equipment (feeding pump, oxygen tank, etc.) or other necessary supplies; accompanying the student between locations to facilitate assistance with needed ADLs or assistance with carrying equipment or other necessary supplies. Escort includes monitoring a student's behaviors that create an unsafe situation for the student, such as removing a seatbelt, attempting to open the vehicle door while the vehicle is in motion, or elopement. Escort duration includes the entire time that the PCS provider accompanies the student during a SHARS-eligible service or health care service on or off campus.
Meal preparation	Assisting the student in preparing meals and snacks, including cooking; assembling ingredients; cutting, chopping, grinding, or pureeing food; setting out food and utensils; serving food; preparing and pouring a predetermined amount of liquid nutrition; cleaning the feeding tube; cleaning the area after a meal; and washing dishes
Medication assistance	Assisting the student with oral medications that are normally self-administered
Money management	Assisting the student with managing their day-to-day finances, including paying bills and adhering to a budget
Telephone use or other communication	Assisting the student in making or receiving telephone calls, managing, and setting up communication devices, and sending and receiving communication for the student

Note: *For students receiving services in a school-based residential program managed by the LEA, the LEA may be reimbursed for the additional ADLs and IADLs listed in subsection 2.12.2, "Services, Benefits, and Limitations," in the Children's Services Handbook (Vol. 2, Provider Handbooks), as appropriate.*

PCS does not include the following:

- ADLs or IADLs that a typically developing child of the same chronological age could not safely and independently perform without adult supervision
- Services that provide direct intervention when the student has the physical, behavioral, and cognitive abilities to perform the ADL or IADL without adult supervision
- Services used for or intended to provide respite care, childcare, or restraint of a student
- Stand-by supervision related to safety
- Teaching a life skills or vocational curriculum
- Services delivered solely for the purpose of education, such as reading, English, language arts, writing, mathematics, science, social studies, physical education, functional curriculum, or electives
- Orientation and mobility or sign language interpretive services

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- Any form of assistance that does not facilitate the above-listed ADLs and IADLs. Supervision, monitoring, cueing, and redirection are not independently considered ADLs or IADLs, but may be used to facilitate the completion of ADLs and IADLs.

PCS may be billed simultaneously with another SHARS-eligible service if the student is receiving assistance with ADLs and IADLs from a PCS provider while receiving the SHARS-eligible service from another provider.

PCS may not be billed for activities that are encompassed in the other SHARS-eligible service being provided by the same provider.

Only the time spent on authorized PCS tasks for each student is eligible for reimbursement.

For PCS services to be reimbursed they must be listed in the student's IEP.

If PCS are provided on the bus, documentation of the type of personal care service that was performed must be included on service logs. Personal care services provided on a bus shall not be provided by a bus monitor, bus aide, or transportation aide.

PCS may be provided in a group setting. A provider may perform PCS for more than one student over the span of the day as long as each student's care is based on their IEP and needs. The time the provider is assisting one student must not overlap with the time the provider is working with another student. PCS must be provided to one student at a time but may be provided to multiple students sequentially.

Personal Care Services Procedure Codes

Procedure Code	Setting	Unit of Service
T1019 with modifier U5	Individual, School	15 minutes
T1019 with modifier U6	Individual, Bus	Per one-way trip

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Procedure code T1019 with modifier U6 may not be billed more than a total of four one-way trips per day.

Personal Care Services Modifiers

Modifier	Description
U5	Personal care services in school, individual
U6	Personal care services on the bus, individual per one-way trip

2.3.5 Physical Therapy (PT) Services

Physical therapy services include, but are not limited to, the following:

- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect
- Evaluation of the purpose of determining the nature, extent, and degree of the need for physical therapy services
- Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems
- A PT evaluation includes evaluating the student's ability to move throughout the school and participate in classroom activities and the identification of movement dysfunction and related functional problems.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

A prescription is required for PT services. The prescription must be updated a minimum of one time every three calendar years.

Physical therapy services must be prescribed by a physician or other eligible prescribing provider. A prescription for PT services must be signed and dated within three calendar years before the initiation of services.

PT services may be reimbursed up to (but not to exceed) the amount designated in the prescription.

In order for PT services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the licensed physician, or other eligible prescribing provider, must be listed on the claim and kept in the student's medical record.

IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate prescription is not required for a re-evaluation.

The need for a re-evaluation should be determined by the student's ARD committee.

The LEA must maintain the prescription in the student's medical record.

Physical therapy must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners to provide PT within his or her licensed scope of practice. A licensed physical therapist assistant (PTA) must act under the supervision of a licensed physical therapist.

Services provided by an unlicensed person acting under the supervision of a licensed physical therapist is not a benefit under Texas Medicaid.

If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.

PT evaluation is billable on an individual basis only. Procedure codes 97161, 97162, and 97163 may be submitted for initial evaluations and re-evaluations.

If an evaluation is performed over several days, the provider must submit the same evaluation procedure code for each evaluation session. The procedure code submitted must reflect the complexity level of the entire evaluation.

The physical therapist who performs the evaluation should use professional clinical judgment to decide which evaluation code to use. The selection of low (procedure code 97161), moderate (procedure code 97162), or high complexity (procedure code 97163) evaluation codes must be based on professional clinical judgment and may not be made by staff other than the rendering therapist.

The physical therapist can only bill time spent with the student present, including time spent helping the student to use adaptive equipment and assistive technology.

Time spent without the student present, such as training teachers or aides to work with the student (unless the student is present during the training time) and report writing, is not billable.

Physical Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
97110 with modifier GP	Individual	Licensed physical therapist	15 minutes
97110 with modifier GP and U1	Individual	Licensed physical therapy assistant	15 minutes
97150 with modifier GP	Group	Licensed physical therapist	15 minutes

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Procedure Code	Individual or Group	Provider	Unit of Service
97150 with modifier GP and U1	Group	Licensed physical therapy assistant	15 minutes
97161 (low), 97162 (moderate), and 97163 (high)	Individual	Licensed physical therapist	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes for procedure codes 97110 and 97150 (therapy services) are required.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

The following direct therapy procedure codes must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day

Procedure Codes	
97110 with modifier GP	97150 with modifier GP
97110 with modifier GP and U1	97150 with modifier GP and U1

The maximum billable time for the following PT evaluation procedure codes is 12 units (three hours), which may be billed over several days within a 30-day period:

Procedure Codes		
97161	97162	97163

Physical Therapy Modifiers

Modifier	Description
GP	PT therapy, individual/group, by licensed therapist
GP and U1	PT therapy, individual/group, by licensed/certified assistant

Note: *PT services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.6 Physician Services

Physician services include diagnostic and evaluation services to determine a child's medically related disabling condition that results in the child's need for services in the school setting.

Physicians are responsible for writing prescriptions for students that require PT or OT services.

In the school setting, speech therapy, and audiology services may be referred by either a physician or other eligible referring provider within the scope of his or her practice under state law in accordance with 42 CFR §440.110(c).

Physician services must be provided by a licensed physician Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Physician services may also be provided by an APRN under the delegation of a physician, or a PA under the delegation of a physician.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following are billable physician services and must be provided on an individual basis:

- The diagnosis or evaluation time spent with the student present.
- The time spent without the student present reviewing the student's records for writing a prescription or referral for specific SHARS services.
- The diagnosis or evaluation time spent with the student present, or the time spent without the student present reviewing the student's records for the evaluation of the sufficiency of an ongoing SHARS service to see whether any changes are needed in the current prescription or referral for that service.
- When reviewing the student's records, the provider must use professional judgment to determine whether or not the student needs to be seen in person.

Procedure code T1023 is limited to 1 unit of service per day.

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

SHARS physician services are billable only when they are provided on an individual basis.

Note: *Physician services delivered via telemedicine are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telemedicine services.

2.3.7 Psychological Services and Counseling

2.3.7.1 Psychological Testing

Psychological Testing Services include the following activities:

- Administering psychological tests and other assessment procedures and interpreting testing and assessment results
- Obtaining, integrating, and interpreting information about a student's behavior and conditions related to learning and functional needs, planning, and managing a program of psychological services
- Evaluating a student for the purpose of determining the student's eligibility for specific psychological, health or related services, the needs for specific SHARS services, and the development or revision of IEP goals and objectives
- Assessing the effectiveness of the delivered services on achieving the goals and objectives of the student's IEP

Billable time includes the following:

- Psychological, educational, or intellectual testing time spent with the student present
- Necessary observation of the student associated with testing
- A parent or teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities
- Test interpretation and report writing

Psychological testing is billable if it leads to the creation of an IEP for a student with disabilities who is eligible for Medicaid and who is 20 years of age or younger, whether or not the IEP includes SHARS.

An assessment write-up during an ARD meeting is billable, however, participation in the ARD meeting itself is not billable under SHARS.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Psychological testing (procedure codes 96130 and 96131) must be provided by a professional who is a licensed specialist in school psychology (LSSP), a licensed psychologist, or a licensed psychiatrist in accordance with 19 TAC 89.1040(b)(1) and 42 CFR 440.60(a).

A prescription is not needed to provide psychological testing through SHARS.

When billing, minutes of psychological testing are not accumulated over multiple days. Psychological testing can only be billed based on accumulated time per calendar day.

The following one-hour procedure codes are limited to eight hours (8 units) over a 30-day period:

Procedure Code	Unit of Service
96130	Initial (1 hour)
96131	Each additional hour

Important: *One unit (1.0) is equivalent to one hour or 60 minutes. Providers may bill in partial hours, expressed as 1/10th of an hour (six-minute segments). For example, express 30 minutes as a billed quantity of 0.5.*

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Time spent for the interpretation of testing results without the student present is billable time.

2.3.7.2 Counseling Services

Counseling services include, but are not limited to, the following:

- Assisting the child or parents in understanding the nature of the child's disability
- Assisting the child or parents in understanding the special needs of the child
- Assisting the child or parents in understanding the child's development
- Assisting to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to the prevention, treatment, or management of physical health problems
- Assessing the need for specific counseling services
- To help a child with a disability benefit from special education

Counseling services must be provided by one of the following:

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Counseling services may also be delivered by a psychologist, psychiatrist, or a licensed psychological associate.

Note: *Medicaid does not allow services delivered by LPC, LCSW, or LMFT interns to be billed under SHARS.*

A prescription is not needed to provide counseling services through SHARS.

LEAs may receive reimbursement for emergency counseling services if the student's IEP includes a behavior improvement plan (BIP) that documents the need for emergency services.

Health and Behavior Assessment and Intervention (HBAI) services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors important to prevention, treatment, or management of physical health symptoms.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following HBAI procedure codes (96158, 96159, 96164, and 96165) are limited to three units (one hour) per day, cumulative between procedure codes (initial procedure code plus two additional 15 minutes), same procedure, same provider:

- The initial 30 minutes (procedure codes 96158 and 96164) are limited to one unit per day.
- Each additional 15 minutes (procedure codes 96159 and 96165) are limited to two units per day.

Procedure Code	Individual or Group	Unit of Service	Provider Type
96158 with modifier UB	Individual	30 minutes	LPC, LCSW, LMFT
96159 with modifier UB (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier UB	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier UB (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT

Individual psychotherapy is defined as therapy that focuses on a single person.

The following individual psychotherapy procedure codes (90832, 90834, and 90837) are limited to two services per day, same procedure, same provider, and will be denied as follows:

- Procedure codes 90834 and 90837 will be denied if submitted on the same day as procedure code 90832.
- Procedure codes 90832 and 90837 will be denied if submitted on the same day as procedure code 90834.
- Procedure codes 90832 and 90834 will be denied if submitted on the same day as procedure code 90837.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier UB	Individual	30 minutes	LPC, LCSW, LMFT
90834 with modifier UB	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier UB	Individual	60 minutes	LPC, LCSW, LMFT

Group psychotherapy is a type of psychotherapy that involves one or more therapists working with several clients at the same time.

Group psychotherapy (procedure code 90853) is limited to one service per day, same procedure, same provider.

Procedure codes 90832, 90834, and 90837 will be denied if submitted on the same day as 90853.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90853 with modifier UB	Group	Untimed, one per date of service	LPC, LCSW, LMFT

Session notes are required for all counseling services.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Counseling Services Delivered by Licensed/Certified Therapist Modifier

Modifier	Description
UB	Counseling services, individual/group, by LPC, LCSW, LMFT

Note: *Counseling services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.7.3 Psychological Services

Psychological services are counseling services provided to help a child with a disability benefit from special education and must be listed in the IEP.

Psychological services must be provided by a licensed psychiatrist, a licensed psychologist, or an LSSP.

LEAs may contract for specific types of psychological services, such as clinical psychology, counseling psychology, neuropsychology, and family therapy, that are not readily available from the LSSP who is employed by the LEA. 22 TAC §465.38 (Psychological Services for Schools) does not prohibit public schools from contracting with licensed psychologists, licensed psychological associates, and provisionally licensed psychologists who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. Such contracting must be on a short-term or part-time basis and cannot involve the broad range of school psychological services listed in 22 TAC §465.38(b)(1).

LEAs may receive reimbursement for emergency psychological services if the student's IEP includes a behavior improvement plan that documents the need for the emergency services. These services may exceed the one-hour daily limit.

HBAI services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors important to prevention, treatment, or management of physical health symptoms.

The following HBAI procedure codes (96158, 96159, 96164, and 96165) are limited to three units (one hour) per day, cumulative between procedure codes (initial procedure code plus two additional 15 minutes) same procedure, same provider, for non-emergency situations:

- The initial 30 minutes (procedure codes 96158 and 96164) are limited to one unit per day.
- Each additional 15 minutes (procedure codes 96159 and 96165) are limited to two units per day.

Procedure Code	Individual or Group	Unit of Service	Provider Type
96158 with modifier AH	Individual	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96159 with modifier AH (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96164 with modifier AH	Group	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
96165 with modifier AH (add-on procedure code)	Group	15 minutes	Licensed psychiatrist, Licensed psychologist, LSSP

Individual psychotherapy is defined as therapy that focuses on a single person.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following individual psychotherapy procedure codes (90832, 90834, and 90837) are limited to two services per day, same procedure, same provider, and will be denied as follows:

- Procedure codes 90834 and 90837 will be denied if submitted on the same day as 90832.
- Procedure codes 90832 and 90837 will be denied if submitted on the same day as 90834.
- Procedure codes 90832 and 90834 will be denied if submitted on the same day as 90837.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH	Individual	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
90834 with modifier AH	Individual	45 minutes	Licensed psychiatrist, Licensed psychologist, LSSP
90837 with modifier AH	Individual	60 minutes	Licensed psychiatrist, Licensed psychologist, LSSP

Group psychotherapy is a type of psychotherapy that involves one or more therapists working with several clients at the same time.

Group psychotherapy (procedure code 90853) is limited to one service per day, same procedure, same provider.

Procedure codes 90832, 90834, and 90837 will be denied if submitted on the same day as procedure code 90853.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90853 with modifier AH	Group	Untimed, one per date of service	Licensed psychiatrist, Licensed psychologist, LSSP

Session notes are required for all psychological services.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

Note: *Psychological services delivered via telehealth or telemedicine are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth and telemedicine services.

2.3.8 Special Transportation Services

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially adapted vehicle to serve the needs of the disabled
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
- The Medicaid services covered by SHARS are included in the student's IEP

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- The special transportation service is included in the student's IEP

Transportation services are provided on a specially adapted school bus to or from the location where the school-based service is provided.

A specially adapted vehicle is one that has been physically modified (e.g., addition of a wheelchair lift, addition of harnesses, or addition of child protective seating).

If an LEA already provides a modification for all students, then the modification is not considered a special adaptation.

Bus monitor or other personnel accompanying children on the bus is not considered an allowable special adaptive enhancement for Medicaid reimbursement under SHARS specialized transportation.

The student's IEP must document the need for transportation to be provided on a specially adapted vehicle.

Specialized transportation services reimbursable under SHARS requires the Medicaid enrolled special education student has the following documented in his or her IEP:

- The student requires a specific physical adaptation or adaptations of a vehicle in order to be transported
- The reason the student needs the specialized transportation

If a SHARS student rides the regular school bus to and from school with other nondisabled students, then that student is not required to have specialized transportation services listed in their IEP.

The cost of the regular school bus ride cannot be billed to SHARS.

The fact that a child may receive a service through SHARS does not necessarily mean that transportation services may be reimbursable.

Reimbursement for covered transportation services is on a per-student one-way trip basis. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on the school's specially adapted vehicle, the following one-way trips may be billed:

- From the student's residence to school
- From the school to the student's residence
- From the student's residence to a provider's office that is contracted with the LEA
- From a provider's office that is contracted with the LEA to the student's residence
- From the school to a provider's office that is contracted with the LEA
- From a provider's office that is contracted with the LEA to the student's school
- From the school to another campus to receive a billable SHARS service
- From the campus where the student received a billable SHARS service back to the student's school

Covered transportation services from a child's residence to school and return are not reimbursable if, on the day the child is transported, the child does not receive Medicaid services covered by SHARS (other than transportation). This service must not be billed by default simply because the student is transported on a specially adapted bus.

Transportation services procedure code T2003 is limited to a total of four one-way trips per day.

2.3.8.1 Documentation for Special Transportation Services

Documentation of each one-way trip provided must be maintained by the LEA (e.g., trip log).

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Trip logs must be maintained daily to record one-way specialized transportation trips. This documentation must also include the number of one-way trips per day and the time for each trip (can be indicated using AM/PM).

At a minimum, trip logs must also include the following:

- Name of the LEA
- Route name or number
- Bus driver's name
- Dates of service and indicate day of the week
- If a service is not provided on a school day, Monday–Friday, mark the student as absent
- Copy of the school district's calendar (to be submitted once during the annual desk review)
- Student's full name and Medicaid number

  Note: *If the Medicaid number is not in the log, a separate ledger detailing student name, date of birth, and Medicaid status and number must be provided.*

- Dated signature of the bus driver

  Note: *Dated signatures should be captured after all trips have been documented.*

LEAs must adhere to all HIPAA and FERPA guidelines when documenting and submitting special transportation logs.

2.3.9 Speech and Language Services

Speech and language services include, but are not limited to, the following:

- Identification of students with speech or language disorders
- Diagnosis and appraisal of specific speech or language disorders
- Referral for medical or other professional attention necessary for the habilitation of speech or language disorders
- Provision of speech or language services for the habilitation or prevention of communicative disorders.

Speech and language services must be delivered by a qualified speech-language pathologist (SLP) holding an unrestricted Texas state license to provide services independently.

Speech and language services may also be delivered by a licensed SLP intern acting under the supervision and direction of a licensed SLP, or a licensed assistant in speech-language pathology acting under the supervision and direction of a licensed SLP.

A referral is required for ST services. The referral must be updated a minimum of one time every three calendar years.

The LEA must maintain the referral in the student's medical record.

Speech and language services must be referred by a physician or other eligible referring provider. A referral for speech therapy services must be signed and dated within three calendar years before the initiation of services.

In order for ST services to be reimbursed through SHARS, the name and national provider identifier (NPI) of the referring licensed physician, or other eligible referring provider, must be listed on the claim and kept in the medical record.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Within SHARS, Medicaid-enrolled SLPs who may practice independently may refer for their own services or those of another SHARS provider of the same discipline. They may not refer for any services outside of SHARS or for other SHARS services of other disciplines.

A speech evaluation that documents the medical necessity for speech therapy may serve as the referral.

SHARS SLPs whose evaluations serve as the referral must be enrolled in Texas Medicaid as either individual practitioners or ordering, referring, or prescribing (ORP) providers. When submitting claims for SHARS audiology services, LEAs must include the referring provider's NPI in the referring provider NPI field of the claim form.

IDEA requires that a student receiving SHARS services must have a re-evaluation every three years, which requires current information; unless the parent and the LEA agree that a re-evaluation is unnecessary (IDEA §1414 (a)(2)(B)).

A separate referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee.

2.3.9.1 Supervision Requirements for SLPs

A supervisor of an intern or assistant shall:

- Ensure that all services provided are in compliance with 16 TAC §111.154 and current state licensure

A supervisor of an assistant shall:

- Be responsible for evaluations, interpretation, and case management
- Not designate anyone other than a licensed speech-language pathologist or intern in speech-language pathology to represent speech-language pathology to an Admission, Review, and Dismissal (ARD) meetings, except as provided by 16 TAC §111.51 and §111.52.

A licensed intern or assistant shall abide by the decisions made by his or her supervisor relating to the intern's or assistant's practice and duties. If the supervisor requests that the intern or assistant violate this policy, the Act, or any other law, the intern or assistant shall refuse to do so and immediately notify the Texas Department of Licensing and Regulation (TDLR) and any other appropriate authority.

The SLP who provides the direction must ensure that the personnel who carry out the directives meet the minimum qualifications set forth in the rules of the TDLR that relate to licensed interns or assistants in speech-language pathology.

Speech Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider	Unit of Service
92507 with modifier GN and U8	Individual	Licensed speech-language therapist	Untimed
92507 with modifier GN and U1	Individual	Licensed speech-language assistant	Untimed
92508 with modifier GN and U8	Group	Licensed speech-language therapist	Untimed
92508 with modifier GN and U1	Group	Licensed speech-language assistant	Untimed
92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed speech-language therapist	15 minutes

Refer to: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes are required for procedure codes 92507 and 92508.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Refer to: Subsection 2.4, "Documentation Requirements" in this handbook for additional information relating to documentation requirements for therapy, evaluations, and re-evaluations.

ST evaluation (procedure codes 92521, 92522, 92523, and 92524) is billable on an individual basis only. ST is billable on an individual (procedure code 92507) or group (procedure code 92508) basis.

The maximum billable time for ST evaluation procedure codes 92521, 92522, 92523, and 92524 with modifier GN is 12 units (three hours), which may be billed over several days, within a 30-day period.

Speech evaluation (procedure codes 92521, 92522, and 92523, and 92524) will be denied if submitted on the same date of service as speech therapy (procedure codes 92507 and 92508).

Procedure code 92522 will be denied if submitted on the same date of service as procedure code 92523.

Procedure code 92523 will be denied if submitted on the same date of service as procedure code 92522.

Providers can only bill time spent with the student present, including assisting the student with learning to use adaptive equipment and assistive technology.

Time spent without the student present, such as report writing and training teachers or aides to work with the student (unless the student is present during training), is not billable.

The following direct therapy procedure codes are limited to a total of one unit per day:

Procedure Codes	
92507 with modifier GN and U8	92508 with modifier GN and U8
92507 with modifier GN and U1	92508 with modifier GN and U1

Speech Therapy Modifiers

Modifier	Description
GN	SLP evaluation by licensed speech-language therapist
GN and U1	SLP therapy, individual/group, by licensed/certified speech-language therapy assistant
GN and U8	SLP therapy, individual/group, by licensed speech-language therapist

Note: *ST services delivered via telehealth are a benefit of the SHARS program under Texas Medicaid.*

Refer to: Subsection 2.3.10, "Telehealth and Telemedicine Services" in this handbook for more information on SHARS telehealth services.

2.3.10 Telehealth and Telemedicine Services

LEAs that participate in the SHARS program may be reimbursed for telehealth and telemedicine services delivered to children in school-based settings, or while receiving remote instruction.

A school-based setting is defined in Texas Government Code §548.0203 as a school district or an open enrollment charter school.

Remote instruction is defined according to requirements set forth by TEA and includes technology-based learning in home or community-based settings.

Providers may be reimbursed for telehealth and telemedicine services delivered to children in school-based settings, or while learning remotely with the following criteria:

- Reimbursement for providers is only available when the patient site is a school, home, or community-based setting.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

  - A patient site is the physical location of the student while the service is being rendered.
- Reimbursement for providers is only available when the distant site is a school or office-based setting.
  - A distant site is the physical location of the Texas Medicaid provider rendering the service.
- A telehealth or telemedicine visit may not be conducted if the provider and student are both physically located at the same school at the time the services are rendered.
- All medical necessity criteria for in-person services apply when services are delivered to children in school-based settings.

Providers must be able to defer to the needs of the student receiving services, allowing the mode of service delivery (synchronous audiovisual, synchronous telephone (audio-only), or in-person) to be accessible.

Providers should obtain informed consent for treatment from the student's parent or legal guardian and the student prior to rendering a telehealth or telemedicine service. Verbal consent is permissible and should be documented in the student's medical record.

Services delivered by synchronous audiovisual or synchronous telephone (audio-only) technology may require participation of a parent or caregiver to assist with the treatment.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law.

A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about telehealth or telemedicine and informed consent. All telehealth or telemedicine services must adhere to documentation, privacy, and security requirements as outlined in this handbook and those in the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*).

2.3.10.1 Telehealth Services

Telehealth services are a benefit of Texas Medicaid and SHARS. Telehealth services has the meaning assigned by Texas Occupations Code (TOC) §111.001. Telehealth services are defined as healthcare services, other than telemedicine medical services or a teledentistry service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telehealth services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

LEAs that participate in the SHARS program may be reimbursed for telehealth occupational therapy (OT), physical therapy (PT), speech therapy (ST), counseling, and psychological services.

All other reimbursement and billing guidelines that are applicable to in-person services will also apply when OT, PT, ST, counseling, and psychological services are delivered as telehealth services.

OT, PT, ST, counseling, and psychological telehealth services provided by LEAs during school hours through SHARS may be delivered via synchronous audiovisual technologies.

Synchronous audiovisual technology is defined as an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of HIPAA.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Counseling and psychological telehealth services provided by LEAs during school hours through SHARS may also be delivered via synchronous telephone (audio-only) technologies.

Synchronous telephone (audio-only) technology is defined as an interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of HIPAA.

Synchronous Audiovisual Technology

The following procedure codes may be provided to children eligible through SHARS as telehealth services via synchronous audiovisual technology if clinically appropriate (as determined by the treating provider), safe and agreed to by the student receiving services.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telehealth services provided by synchronous audiovisual technology must be billed using modifier 95.

The following procedure codes must be billed for telehealth services delivered via synchronous audiovisual technology:

Procedure Code	Individual or Group	Unit of Service	Provider
90832 with modifier UB and 95	Individual	30 minutes	LPC, LCSW, LMFT
90832 with modifier AH and 95	Individual	30 minutes	Licensed psychologist, LSSP
90834 with modifier AH and 95	Individual	45 minutes	Licensed psychologist, LSSP
90834 with modifier UB and 95	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier AH and 95	Individual	60 minutes	Licensed psychologist, LSSP
90837 with modifier UB and 95	Individual	60 minutes	LPC, LCSW, LMFT
90853 with modifier AH and 95	Group	Untimed, one per date of service	Licensed psychologist, LSSP
90853 with modifier UB and 95	Group	Untimed, one per date of service	LPC, LCSW, LMFT
92507 with modifier GN, U8, and 95	Individual	Untimed, one per date of service	Licensed speech therapist
92507 with modifier GN, U1, and 95	Individual	Untimed, one per date of service	Licensed speech assistant
92508 with modifier GN, U8, and 95	Group	Untimed, one per date of service	Licensed speech therapist
92508 with modifier GN, U1, and 95	Group	Untimed, one per date of service	Licensed speech assistant
92521, 92522, 92523, or 92524 with modifier GN and 95	Individual	15 minutes	Licensed speech therapist
96158 with modifier AH and 95	Individual	30 minutes	Licensed psychologist, LSSP
96158 with modifier UB and 95	Individual	30 minutes	LPC, LCSW, LMFT

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Procedure Code	Individual or Group	Unit of Service	Provider
96159 with modifier AH and 95 (add-on procedure code)	Individual	15 minutes	Licensed psychologist, LSSP
96159 with modifier UB and 95 (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier AH and 95	Group	30 minutes	Licensed psychologist, LSSP
96164 with modifier UB and 95	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier AH and 95 (add-on procedure code)	Group	15 minutes	Licensed psychologist, LSSP
96165 with modifier UB and 95 (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT
97110 with modifier GP and 95	Individual	15 minutes	Licensed physical therapist
97110 with modifier GP, U1, and 95	Individual	15 minutes	Licensed physical therapy assistant
97150 with modifier GP and 95	Group	15 minutes	Licensed physical therapist
97150 with modifier GP, U1, and 95	Group	15 minutes	Licensed physical therapy assistant
97150 with modifier GO and 95	Group	15 minutes	Licensed occupational therapist
97150 with modifier GO, U1, and 95	Group	15 minutes	Licensed occupational therapy assistant
97161 (low), 97162 (moderate), and 97163 (high) with modifier 95	Individual	15 minutes	Licensed physical therapist
97165 (low), 97166 (moderate), and 97167 (high) with modifier 95	Individual	15 minutes	Licensed occupational therapist
97530 with modifier GO and 95	Individual	15 minutes	Licensed occupational therapist
97530 with modifier GO, U1, and 95	Individual	15 minutes	Licensed occupational therapist assistant

Synchronous Telephone (Audio-Only) Technology

The following procedure codes may be provided to children eligible through SHARS as telehealth services via synchronous telephone (audio-only) technology to students with whom the treating provider has an 'established relationship' and if clinically appropriate (as determined by the treating provider), safe, and agreed to by the student receiving services.

HHSC encourages the use of synchronous audiovisual technology over telephone (audio-only) delivery of telehealth services whenever possible. Therefore, if delivered by synchronous telephone (audio-only) technology, providers must document in the student's medical record the reason(s) for why a synchronous audiovisual platform was not used.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telehealth services provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure Code	Individual or Group	Unit of Service	Provider
90832 with modifier AH and 93	Individual	30 minutes	Licensed psychologist, LSSP
90832 with modifier UB and 93	Individual	30 minutes	LPC, LCSW, LMFT
90834 with modifier AH and 93	Individual	45 minutes	Licensed psychologist, LSSP
90834 with modifier UB and 93	Individual	45 minutes	LPC, LCSW, LMFT
90837 with modifier AH and 93	Individual	60 minutes	Licensed psychologist, LSSP
90837 with modifier UB and 93	Individual	60 minutes	LPC, LCSW, LMFT
90853 with modifier AH and 93	Group	Untimed, one per date of service	Licensed psychologist, LSSP
90853 with modifier UB and 93	Group	Untimed, one per date of service	LPC, LCSW, LMFT
96158 with modifier AH and 93	Individual	30 minutes	Licensed psychologist, LSSP
96158 with modifier UB and 93	Individual	30 minutes	LPC, LCSW, LMFT
96159 with modifier AH and 93 (add-on procedure code)	Individual	15 minutes	Licensed psychologist, LSSP
96159 with modifier UB and 93 (add-on procedure code)	Individual	15 minutes	LPC, LCSW, LMFT
96164 with modifier AH and 93	Group	30 minutes	Licensed psychologist, LSSP
96164 with modifier UB and 93	Group	30 minutes	LPC, LCSW, LMFT
96165 with modifier AH and 93 (add-on procedure code)	Group	15 minutes	Licensed psychologist, LSSP
96165 with modifier UB and 93 (add-on procedure code)	Group	15 minutes	LPC, LCSW, LMFT

2.3.10.2 Telemedicine Services

Telemedicine medical services, also known as telemedicine services, are a benefit of Texas Medicaid and SHARS. Telemedicine medical services has the meaning assigned by TOC §111.001. Telemedicine services are defined as health care services delivered by a physician licensed in the state of Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas and

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Telemedicine medical services must be provided in compliance with standards established by the respective licensing or certifying board of the professional providing the services.

LEAs that participate in the SHARS program may be reimbursed for telemedicine psychological and physician services.

All other reimbursement and billing guidelines that are applicable to in-person services will also apply when psychological and physician services are delivered as telemedicine services.

Psychological and physician telemedicine services provided by LEAs during school hours through SHARS may be delivered via synchronous audiovisual technologies.

Synchronous audiovisual technology is defined as an interactive, two-way audio and video telecommunications platform that meets the privacy requirements of HIPAA.

Psychological telemedicine services provided by LEAs during school hours through SHARS may also be delivered via synchronous telephone (audio-only) technologies.

Synchronous telephone (audio-only) technology is defined as an interactive, two-way audio telecommunications platform, including telephone technology, that uses only sound and meets the privacy requirements of HIPAA.

Synchronous Audiovisual Technology

The following procedure codes may be provided to children eligible through SHARS as telemedicine services via synchronous audiovisual technology if clinically appropriate (as determined by the treating provider), safe and agreed to by the student receiving services.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telemedicine services provided by synchronous audiovisual technology must be billed using modifier 95.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH and 95	Individual	30 minutes	Licensed psychiatrist
90834 with modifier AH and 95	Individual	45 minutes	Licensed psychiatrist
90837 with modifier AH and 95	Individual	60 minutes	Licensed psychiatrist
90853 with modifier AH and 95	Group	Untimed, one per date of service	Licensed psychiatrist
96158 with modifier AH and 95	Individual	30 minutes	Licensed psychiatrist
96159 with modifier AH and 95 (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist
96164 with modifier AH and 95	Group	30 minutes	Licensed psychiatrist
96165 with modifier AH and 95 (add-on procedure code)	Group	15 minutes	Licensed psychiatrist

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Procedure Code	Individual or Group	Unit of Service	Provider Type
T1023 with modifier 95	Individual	Untimed	MD, DO

Synchronous Telephone (Audio-Only) Technology

The following procedure codes may be provided to children eligible through SHARS as telemedicine services via synchronous telephone (audio-only) technology to students with whom the treating provider has an 'established relationship' and if clinically appropriate (as determined by the treating provider), safe, and agreed to by the student receiving services.

HHSC encourages the use of synchronous audiovisual technology over telephone (audio-only) delivery of telemedicine services whenever possible. Therefore, if delivered by synchronous telephone (audio-only) technology, providers must document in the student's medical record the reason(s) for why a synchronous audiovisual platform was not used.

The patient site must be a school, home, or community-based setting in order for the distant site provider to be eligible for reimbursement of these services.

All telemedicine services provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure Code	Individual or Group	Unit of Service	Provider Type
90832 with modifier AH and 93	Individual	30 minutes	Licensed psychiatrist
90834 with modifier AH and 93	Individual	45 minutes	Licensed psychiatrist
90837 with modifier AH and 93	Individual	60 minutes	Licensed psychiatrist
90853 with modifier AH and 93	Group	Untimed, one per date of service	Licensed psychiatrist
96158 with modifier AH and 93	Individual	30 minutes	Licensed psychiatrist
96159 with modifier AH and 93 (add-on procedure code)	Individual	15 minutes	Licensed psychiatrist
96164 with modifier AH and 93	Group	30 minutes	Licensed psychiatrist
96165 with modifier AH and 93 (add-on procedure code)	Group	15 minutes	Licensed psychiatrist

Refer to: *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on restrictions for services delivered by synchronous telephone (audio-only) technologies.

2.3.11 Prior Authorization

Prior authorization is not required for Medicaid services provided by a SHARS provider.

2.4 Documentation Requirements

Documentation of services should be generated at the time of service or shortly thereafter, in order to maintain an accurate medical record. Documentation of services must occur within 1 week (7 days) of the time the service is rendered.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following service log documentation is required for all SHARS services prescribed in the student's IEP or Section 504 plan:

- Student's name
- Student's date of birth
- Student's Medicaid identification number on every page of the chart/record/note
- Date of service; and for each date of service:
  - Billable start and stop time
  - Total billable minutes
  - Student observation
  - Procedure code(s)
  - Note activity performed. Documentation of service provided must support the services billed.
- The SHARS provider's printed name, title, and original handwritten or electronic signature
  - Any electronic signature technologies that are used must comply with all federal and state statutes and administrative rules.

Service logs for PCS must include all elements of a SHARS service log with the following:

- The specific PCS task
- The total billable minutes for each ADL and IADL recorded

The total billable minutes for PCS are determined by the combined total billable minutes for each ADL and IADL recorded.

The total billable minutes for PCS performed by a PCS provider cannot exceed the PCS provider's total number of hours at the place of service.

Session notes for evaluations are not required; however, documentation must include the billable start time, billable stop time, and total billable minutes with a notation of the activity performed (e.g., audiology evaluation, speech therapy evaluation). Service providers are expected to perform and document evaluations in accordance with discipline-specific standards of practice and retain records in the student's file.

Session notes are required for therapy. Session notes must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

Session notes will include all elements of a service log plus:

- Student's progress towards goals (if applicable)
- Note whether the service was provided individually or in a group
- The related IEP objective

If a SHARS provider is supervising an assistant or intern, then the supervising provider must adhere to current state licensure signature requirements.

All SHARS services require documentation to support the medical necessity of the service rendered. SHARS services are subject to retrospective review and recoupment if documentation does not support the service billed.

The following are mandatory general requirements for all providers:

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

- All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- Each page of the medical record documents the client's name and Texas Medicaid number.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information on additional mandatory general documentation requirements for all providers.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

2.4.1 Record Retention

Student-specific records that are required for SHARS become part of the student's educational records and must be maintained for seven years. All records that are pertinent to SHARS must be maintained by the LEA until all audit questions, appeal hearings, investigations, or court cases are resolved. Records must be stored in a secure and readily accessible location and format and must be available for state or federal audits.

The following is a checklist of the minimum documents to collect and maintain:

- Signed consent to bill Medicaid by parent or guardian
- IEP
- Current provider qualifications (licenses)

  Note: *Qualified PCS provider documentation must include a signed and dated statement from a qualified employee of the LEA, as described by the PCS Provider Requirements, verifying the individual is able to perform PCS tasks in accordance with the required PCS competence areas. Supporting documents or information must also be included as applicable.*
- Attendance records
- Prescriptions and referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures, for each service/event
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories
- Assessments/evaluations
- Written agreements (contracts) for contracted service providers
- Copies of signed Certification of Funds (COF) letters and supporting documentation, including quarterly COF reports
- E-signature authorization forms(s) if applicable

2.5 Managed Care Clients

SHARS services are available to clients regardless of Medicaid service delivery mechanism (traditional Medicaid or Medicaid Managed Care). SHARS services are carved-out of the Medicaid Managed Care Program and must be billed to TMHP for payment consideration. Carved-out services are those that are rendered to Medicaid Managed Care clients but are administered by TMHP and not the client's Managed Care Organization (MCO).

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

2.6 Third Party Liability

SHARS claims are subject to Third Party Liability via the pay and recover later method.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*) for more information.

2.7 Claims Filing and Reimbursement

2.7.1 Claims Information

Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the federal fiscal year (FFY) (i.e., January 3), whichever comes first.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims and additional general information about claims filing.

2.7.1.1 Appealing Denied SHARS Claims

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal. Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations.

Each page of the documentation must have the student's name and Medicaid number.

2.7.2 Reimbursement Guidelines: Cost Reporting and Interim Claims

During the cost report period, LEAs participating in SHARS are reimbursed on an interim claiming basis using SHARS interim rates. In order to accommodate participating SHARS districts that require interim cash flow to offset the financial burden of providing for students, an interim fee-for-service claiming system still exists for SHARS. It is important that SHARS providers understand that SHARS interim payments are provisional in nature. Providers are reimbursed for direct medical services and transportation services provided under the SHARS Program on a cost basis using federally mandated allocation methodologies in accordance with 1 TAC §355.8443.

There is no lifetime benefit cap for SHARS services provided so long as the services are medically necessary and documented in the student's IEP. The services provided to the student at the school do not affect the type or amount of Medicaid services the student receives outside the school setting.

2.7.2.1 Interim Claiming

LEAs must submit the following:

- At least one interim claim for each direct medical service that an eligible student receives within the cost report period.
- Interim claims for all personal care services that an eligible student receives within the cost report period
- Interim claims for all eligible specialized transportation trips provided within the cost report period.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Untimed Units

For untimed procedure codes, claims that are submitted for reimbursement must include one unit of service for each unit billed. Untimed codes are reimbursed on a per unit basis and are subject to frequency limitations for each SHARS service category.

Timed Units

For timed procedure codes, providers must only report billable time when the midpoint of the total duration for the procedure code has been passed. All claims for reimbursement of timed procedure codes are based on the actual amount of billable time associated with the SHARS service.

For those services for which the unit of service is 15 minutes based on code description for SHARS services (i.e., 1 unit = 15 minutes), partial units must be rounded up or down to the nearest quarter hour for 15-minute units.

Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information may be reimbursed as a unit of 1.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to 0 units of service if they are seven or fewer minutes.

For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Examples of Billing Units Based on 15 Minutes

Minutes	Units
0 min - 7 mins	0 units
8 mins - 22 mins	1 unit
23 mins - 37 mins	2 units
38 mins - 52 mins	3 units
53 mins - 67 mins	4 units
68 mins - 82 mins	5 units

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service.

For 30-minute codes at least 16 minutes must pass in order to report a code with 1 unit = 30 minutes.

For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units must be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

To calculate billing units, count the total number of billable minutes for the calendar day for the SHARS student and divide by 60 to convert to billable units of service. If the total billable minutes are not divisible by 60, the minutes are converted to partial units of service as follows:

Examples of Billing Units Based on an Hour

Minutes	Units
0 mins - 3 mins	0 units

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Minutes	Units
4 mins - 9 mins	0.1 unit
10 mins - 15 mins	0.2 unit
16 mins - 21 mins	0.3 unit
22 mins - 27 mins	0.4 unit
28 mins - 33 mins	0.5 unit
34 mins - 39 mins	0.6 unit
40 mins - 45 mins	0.7 unit
46 mins - 51 mins	0.8 unit
52 mins - 57 mins	0.9 unit
58 mins - 63 mins	1 unit
64 mins - 69 mins	1.1 units
70 mins - 75 mins	1.2 units
76 mins - 81 mins	1.3 units
82 mins - 87 mins	1.4 units
88 mins - 93 mins	1.5 units

2.7.2.2 Cost Reporting

The total allowable costs for providing services for SHARS must be documented by submitting the required annual cost report.

The provider's final reimbursement amount is arrived at by a cost report, cost reconciliation, and cost settlement process. The provider's total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies.

The provider's interim payments will be reimbursed in compliance with 1 TAC §355.8443.

Submittal of a SHARS cost report is mandatory for each provider that requests and receives interim payments. Failure to file a SHARS cost report will result in sanctions, which includes recoupment of all interim payments for the cost report period in which the default occurs.

CMS requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by LEAs. CMS requires that LEAs, as public entities, not be paid in excess of their Medicaid-allowable costs and that any overpayments be recouped through the cost reconciliation and cost settlement processes. In an effort to minimize any potential recoupments, HHSC has assigned SHARS interim rates that are as close as possible to each district's Medicaid allowable costs for providing each SHARS service.

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous FFY (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

The following certification forms must be submitted and received by HHSC for the cost report. The annual cost report includes two certification forms which must be completed to certify the provider's incurred actual costs:

- Cost report certification
- Claimed expenditures

The certification forms received by HHSC for the cost report must be:

- The original certification pages.
- Signed by the business officer or other financial representative who is responsible for legally binding the district.
- Notarized.

The primary purpose of the cost report is to document the provider's costs for delivering SHARS, including direct costs and indirect costs, and to reconcile the provider's interim payments for SHARS with its actual total Medicaid-allowable costs.

All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

2.7.2.3 Cost Reconciliation and Cost Settlement

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report. The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.

If a provider has not complied with all cost report requirements or a provider's interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment by one of the following methods:

- Offset all future claims payments to the provider until the amount of the federal share of the overpayment is recovered
- Recoup an agreed-upon percentage from future claims payments to the provider to ensure recovery of the overpayments within one year
- Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the overpayment within one year

If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC issues a notice of settlement that denotes the amount due to or from the provider.

2.7.2.4 * Informal Review of Cost Reports Settlement

An LEA or the Superintendent, Chief Financial Officer, Business Officer, or other LEA Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments. Requests for informal reviews must be sent by certified mail and received by HHSC within the time frame designated on the settlement notice. Furthermore, the request for informal review must include a concise statement of the specific actions or determinations the LEA disputes, the LEA's recommended resolution, and any supporting documentation deemed relevant to the dispute. Failure to follow these instructions will result in the denial of the request for an informal review.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

[Revised] For more information on the Cost Report and SHARS interim rates please reference the Cost Report Instructions and the HHSC Rate Analysis SHARS webpage at pfd.hhs.texas.gov/acute-care/school-health-and-related-services-shars. Further information can be found in 1 TAC §355.8443.

SHARS providers can also contact a SHARS Rate Analyst by email at ProviderFinance-SHARS@hhs.texas.gov or by telephone at 512-730-7400.

Refer to: "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information on reimbursement and the Federal Medical Assistance Percentage (FMAP).

2.7.2.5 Quarterly Certification of Funds

SHARS providers are required to certify on a quarterly basis the amount reimbursed during the previous federal fiscal quarter. TMHP Provider Enrollment mails the quarterly Certification of Funds statement to SHARS providers after the end of each quarter of the FFY (October 1 through September 30). The purpose of the statement is to verify that the LEA incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service. While the payments were received the previous FFY, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the dates of the FFY quarter and not the dates of service paid within the quarter.

In order to balance amounts in the Certification of Funds, providers will receive, or have access to, the Certification of Funds Claims Information Report. For help balancing the amounts in the statement, providers can contact the TMHP Contact Center at 800-925-9126.

Refer to: "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

The Certification of Funds statement must be:

- Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
- Notarized.
- Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to do so may result in recoupment of funds or the placement of a vendor hold on the provider's payments until the signed Certification of Funds statement is received by TMHP. Providers must contact the TMHP Contact Center at 800-925-9126 if they do not receive their Certification of Funds statement.

On an annual basis, SHARS providers are required to certify through their cost reports their total, actual, incurred costs, including the federal share and the nonfederal share.

Refer to: Subsection 2.7.2, "Reimbursement Guidelines: Cost Reporting and Interim Claims" in this handbook for additional information about cost reporting.

2.8 * Random Moment Time Study (RMTS)

CMS requires SHARS providers to participate in the RMTS to be eligible to submit claims and receive reimbursement for SHARS services. SHARS providers must comply with the Texas Time Study Guide, which includes, but is not limited to, Mandatory Annual RMTS Contact training certification of RMTS participants for all four annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The four annual RMTS quarters are October through December, January through March, April through June, and July through September.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

An existing LEA can only become a SHARS provider effective October 1, each year and they must participate in all four RMTS quarters for that annual period. SHARS providers that do not participate in all four required RMTS quarters, or are RMTS non-compliant, cannot be a SHARS provider for that entire annual period (October 1 through September 30) and will be required to return any Medicaid payments received for SHARS services delivered during that annual cost report period. The LEA can return to participating in the SHARS program the following FFY beginning on October 1.

A new LEA (i.e., a newly formed district that began operations after October 1) can become a SHARS provider effective with the first day of the federal quarter in which it participates in the RMTS. New SHARS providers may not submit claims or be reimbursed for SHARS services provided prior to the RMTS quarter in which they begin to participate, and they must participate in all remaining RMTS quarters for that annual period.

[Revised] LEAs can access the Texas Time Study Guide, on the HHSC website at pfd.hhs.texas.gov/acute-care/time-study.

SHARS providers can contact the HHSC Time Study Unit by email at TimeStudy@hhsc.texas.gov or by telephone at 512-491-1715.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.