



Texas Medicaid Provider Procedures Manual

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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

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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.

Local Education Agencies (LEAs), which include Texas 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-eligible students in a school setting.

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

According to the 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 eligible students must:

- Be enrolled in a public school’s special education program; and
- Be 20 years of age or younger; and
- Have a disability or chronic medical condition; and
- Have an IEP, documenting medical necessity or a prescription for services.

- 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.
- 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.

SHARS covers the following services:

- Audiology, individual and group, delivered by licensed master's level therapist or licensed assistant
- 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 ISD or under contract with the ISD.*

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 PT, OT, and ST providers and non-SHARS PT, OT, 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).

Reimbursement is available for PT, OT, 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. 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.

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 and Texas Department of Licensing and Regulation.

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 EPSDT Services
- 1 TAC § 355.8443 Reimbursement Methodology for SHARS
- 1 TAC § 355.101 - § 355.114 Cost Determination Process

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 (such as, PT or OT) from the ordering physician or other eligible prescribing provider.

A referral is defined as a written document requesting evaluation for services (such as, ST or Audiology) from the referring physician or other eligible referring provider.

2.1.1 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 three annual RMTS quarters, and compliance with participation requirements for selected sampled moments. The three annual RMTS quarters are October through December, January through March, and April through June. A July through September RMTS is not conducted.

An existing school district can only become a SHARS provider effective October 1, each year and they must participate in all three RMTS quarters for that annual period. SHARS providers that do not participate in all three 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 school district can return to participating in the SHARS program the following federal fiscal year beginning on October 1.

A new school district (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.

School districts can access the Texas Time Study Guide, on the HHSC website at <https://pfd.hhs.texas.gov/time-study/time-study-independent-school-districts-isd>

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

2.1.2 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 independent school district (ISD) or public charter 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 public school districts 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 (school district) 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.

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.

Referto: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information.

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

To be reimbursed for hearing aid devices and accessories, and fitting and dispensing visits and revisits, 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. Hearing aids and fittings are not covered by the SHARS program.

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

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 medical record. Audiologists whose evaluations serve as the referral must be enrolled in Medicaid as individual practitioners and must use their individual NPI for claim submission.

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 physician's referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee. The school district must maintain the referral in the client's record.

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

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.

2.3.1.1 Audiology Services Procedure Codes

Procedure Code	Individual or Group	Provider
92507 with modifier U1	Individual	Licensed assistant
92507 with modifier U9	Individual	Licensed audiologist
92508 with modifier U1	Group	Licensed assistant
92508 with modifier U9	Group	Licensed audiologist
92553	Individual	Licensed audiologist
92556	Individual	Licensed audiologist
92557	Individual	Licensed audiologist
92592	Individual	Licensed audiologist
92593	Individual	Licensed audiologist
92620	Individual	Licensed audiologist
92621	Individual	Licensed audiologist

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

Procedure Code	Modifier
92507	U1
92507	U9
92508	U1
92508	U9

Referto: Subsection 2.7.2.1, “Interim Claiming” in this handbook

2.3.1.2 Audiology Services Modifiers

Modifier	Description
U1	Audiology services provided by a licensed assistant, individual or group
U9	Audiology services provided by a licensed audiologist, individual or group

Audiology therapy is billable on an individual (procedure code 92507) and group (procedure code 92508) basis.

Session notes for therapy services (procedure codes 92507 and 92508) are required.

Audiology evaluation (procedure codes 92620 and 92621) is billable on an individual basis only. The maximum billable time for an audiology evaluation (procedure code 92620) is 60 minutes (1 unit). The maximum billable time for an audiology evaluation (each additional 15 minutes - procedure code 92621) is 60 minutes (4 units).

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

Audiology evaluation (procedure codes 92620 and 92621) will be denied if submitted on the same date of service as audiology therapy (procedure codes 92507 and 92508).

Pure tone audiometry (procedure code 92553) is limited to one per day, any provider. This service includes testing of both ears. Audiologists must use modifier 52, reduced services, if a test is applied to one ear instead of both.

Speech audiometry threshold (procedure code 92556) is limited to one per day, any provider. This service includes testing of both ears. Audiologists must use modifier 52, reduced services, if a test is applied to one ear instead of both.

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service, same provider, and same client, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Hearing aid check – one ear (procedure code 92592) and hearing aid check – two ears (procedure code 92593) are not reimbursed on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service, same provider, and same client, procedure code 92593 will be reimbursed and procedure code 92592 will be denied.

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.

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

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

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 registered nurse (RN) or advanced practice registered nurse (APRN) who can make that determination.

Nursing services must be provided by an RN, 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.

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.

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.

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

2.3.2.1 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
T1502 with modifier TD	NA	Medication administration, per visit
T1002 with modifier U7	Delegation, Individual	15 minutes
T1002 with modifier U7 and UD	Delegation, Group	15 minutes
T1502 with modifier U7	NA	Delegation, medication administration, per visit
T1003 with modifier TE	Individual	15 minutes
T1003 with modifier TE and UD	Group	15 minutes
T1502 with modifier TE	NA	Medication, administration per visit

Referto: Subsection 2.7.2.1, “Interim Claiming” in this handbook.

2.3.2.2 Nursing Services Modifiers

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

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, or T1003 with modifier TE and UD are limited to 16 combined units (four hours) per day.

Procedure codes T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE are limited to a total of four medication administration visits per day.

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.

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 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 physician's 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 client's 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.

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

2.3.3.1 Occupational Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider
97165 (low), 97166 (medium), and 97167 (high)	Individual	Licensed therapist
97150 with modifier GO	Group	Licensed therapist
97150 with modifier GO and U1	Group	Licensed therapy assistant
97530 with modifier GO	Individual	Licensed therapist
97530 with modifier GO and U1	Individual	Licensed therapy assistant

Referto: Subsection 2.7.2.1, “Interim Claiming” in this handbook.

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

Direct therapy procedure codes 97150 with modifier GO, 97150 with modifier GO and U1, 97530 with modifier GO, or 97530 with modifier GO and U1 are limited to a combined total of four units (one hour) per day.

The maximum billable time for OT evaluation procedure codes 97165, 97166, or 97167 is 12 units (three hours), which may be billed over several days within a 30-day period.

2.3.4 Personal Care Services

Personal care services are provided to help a child with a disability or chronic condition benefit from special education. Personal care services include a range of human assistance provided to persons with disabilities or chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. An individual may be physically capable of performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment.

PCS include direct intervention (assisting the client in performing a task) or indirect intervention (cueing or redirecting the client to perform a task). ADLs, IADLs, and Health Maintenance Activities (HMAs) include, but are not limited to, the following:

ADLs	IADLs
Bathing	Escort
Dressing	Medication Assistance
Eating	Money Management
Locomotion or Mobility	Telephone use or Other Communication
Personal Hygiene	
Positioning	
Toileting	
Transferring	

Note: HMAs and nurse-delegated tasks that fall within the scope of the task listed above are allowable in PCS.

PCS does not include the following:

- ADLs, IADLs, or HMAs 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 client has the physical, behavioral, and cognitive abilities to perform an ADL, IADL, or health-related function without adult supervision
- Services used for or intended to provide respite care, childcare, or restraint of a client
- Stand-by supervision related to safety
- Teaching a life skills curriculum

A prescription is not needed to provide PCS through SHARS.

For personal care services to be billable, they must be listed in the student's IEP.

2.3.4.1 Personal Care Services Procedure Codes

Procedure Code	Individual or Group/Location	Unit of Service
T1019 with modifier U5	Individual, School	15 minutes
T1019 with modifier U5 and UD	Group, School	15 minutes
T1019 with modifier U6	Individual, Bus	Per one-way trip
T1019 with modifier U6 and UD	Group, Bus	Per one-way trip

Referto: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

The maximum billable units for procedure codes T1019 with modifier U6 or T1019 with modifier U6 and UD is a total of four one-way trips per day.

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.

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 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 physician's order 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 client's 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.

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

2.3.5.1 Physical Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider
97161 (low), 97162 (medium), and 97163 (high)	Individual	Licensed therapist
97110 with modifier GP	Individual	Licensed therapist
97110 with modifier GP and U1	Individual	Licensed therapy assistant
97150 with modifier GP	Group	Licensed therapist
97150 with modifier GP and U1	Group	Licensed therapy assistant

Referto: Subsection 2.7.2.1, “Interim Claiming” in this handbook.

Direct therapy procedure codes 97110 with modifier GP, 97110 with modifier GP and U1, 97150 with modifier GP, or 97150 with modifier GP and U1 must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day.

The maximum billable time for PT evaluation procedure codes 97161, 97162, and 97163 is 12 units (three hours), which may be billed over several days within a 30-day period.

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 (M.D. or D.O.).

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 utilize professional judgement to determine whether or not the student needs to be seen in person.

Procedure code 99499 must be billed in 15-minute increments and is limited to a total of 4 units (one hour) per day.

Referto: Subsection 2.7.2.1, “Interim Claiming” in this handbook.

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

2.3.7 Psychological Testing and Counseling/Psychological Services

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.

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.

Referto: 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/Psychological 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.

School districts 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.

Session notes are required for all counseling services.

2.3.7.3 Counseling Delivered by Licensed/Certified Therapist

The following services are limited to a total of three units (one hour) per day, any provider:

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

The initial 30-minute unit (procedure codes 96158 and 96164) is limited to one unit per day.

Each additional 15-minute unit (procedure codes 96159 and 96165) is limited to two units per day.

Session notes are required for all psychological services.

2.3.7.4 Psychological Services Delivered by Licensed/Certified Psychiatrist or Psychologist

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.

School districts 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 Licensed Specialist in School Psychology (LSSP) who is employed by the school district. 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).

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

The following services are limited to a total of three units (one hour) per day, any provider, for non-emergency situations:

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

The initial 30-minute unit (procedure codes 96158 and 96164) is limited to one unit per day.

Each additional 15-minute unit (procedure codes 96159 and 96165) is limited to two units per day.

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
- 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 seatbelts or harnesses, addition of child protective seating, or addition of air conditioning).

If an LEA already provides a modification for all students, then the modification is not considered a special adaptation. For example, if air conditioning is already provided to all students then air conditioning is not considered a specially adapted modification.

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-eligible 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).

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 should also include the following:

- Name of the LEA
- Route name or number
- Bus driver's name
- Bus aid or bus monitor aid name (if applicable) and initials for each one-way trip
- 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)
- Indication if a bus aid or monitor was needed. Schools may only bill for a bus aid/monitor if this service is prescribed in the child's IEP.
- If Personal Care Services are provided on the bus, documentation of the type of personal care service (type of activity and group/individual) that was performed must be included.
- 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 and bus aid/monitor (if applicable)

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

Reminder: 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.

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

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. Speech therapists whose evaluations serve as the referral must be enrolled in Medicaid as individual practitioners and must use their individual NPI for claim submission.

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 physician's referral is not required for a re-evaluation. The need for a re-evaluation should be determined by the student's ARD committee. The school district must maintain the referral in the client's record.

Speech and language services must be provided by a qualified Speech-Language Pathologist (SLP), who holds a Texas license or an American Speech Language and Hearing Association (ASHA)-equivalent SLP (has a master's degree in the field of speech-language pathology and a Texas license).

Speech and language services can also be provided by an SLP with a TEA certification (according to Texas Occupations Code §401.054), a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of a licensed SLP, or a licensed assistant in speech-language pathology acting under the supervision or direction of an SLP.

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 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.

2.3.9.2 Speech Therapy Services Procedure Codes

Procedure Code	Individual or Group	Provider
92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed therapist
92507 with modifier GN and U8	Individual	Licensed therapist
92507 with modifier GN and U1	Individual	Licensed assistant
92508 with modifier GN and U8	Group	Licensed therapist
92508 with modifier GN and U1	Group	Licensed assistant

Referto: Subsection 2.7.2.1, "Interim Claiming" in this handbook.

Session notes are required for procedure codes 92507 and 92508.

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.

Direct therapy procedure codes 92507 with modifier GN and U8, 92507 with modifier GN and U1, 92508 with modifier GN and U8, or 92508 with modifier GN and U1 must be billed in 15-minute increments and are limited to a combined total of 4 units (one hour) per day.

2.3.10 Telehealth Services

Telehealth services delivered to children in school-based settings are a benefit of Texas Medicaid.

Schools that participate in the SHARS program may be reimbursed for telehealth OT, ST, and Counseling services delivered to children in school-based settings.

A school-based setting is defined in Texas Government Code §531.02171(b) as a school district or an open enrollment charter school.

OT, ST, and Counseling services provided by school districts through SHARS can be delivered during school hours.

Providers may be reimbursed for telehealth services delivered to children in school-based settings with the following criteria:

- Reimbursement for providers is only available when the patient site is a school-based setting.
- All medical necessity criteria and prior authorization requirements for in-person services apply when services are delivered to children in school-based settings.

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

The following procedure codes are reimbursed when rendered as telehealth services to children eligible through SHARS. The patient site must be a school-based setting in order for the distant site provider to be eligible for reimbursement of these services, and all services should be billed using a 95 modifier to denote remote delivery:

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
96158 with modifier AH	Individual	30 minutes	Licensed psychiatrist, Licensed psychologist, LSSP

Procedure Code	Individual or Group	Unit of Service	Provider Type
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

Procedure Code	Individual or Group	Provider Type
97165 (low), 97166 (medium), and 97167 (high)	Individual	Licensed Occupational therapist
97150 with modifier GO	Group	Licensed Occupational therapist
97150 with modifier GO and U1	Group	Licensed Occupational therapy assistant
97530 with modifier GO	Individual	Licensed Occupational therapist
97530 with modifier GO and U1	Individual	Licensed Occupational therapy assistant
92521, 92522, 92523, or 92524 with modifier GN	Individual	Licensed Speech therapist
92507 with modifier GN and U8	Individual	Licensed Speech therapist
92507 with modifier GN and U1	Individual	Licensed Speech assistant
92508 with modifier GN and U8	Group	Licensed Speech therapist
92508 with modifier GN and U1	Group	Licensed Speech assistant

2.3.11 Prior Authorization

Prior authorization through TMHP 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.

The following service log documentation is required for all SHARS services:

- 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.

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, intern, or a grandfathered employee 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.

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)
- 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 MCO.

2.6 Third Party Liability

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

Referto: “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 (i.e., January 3), whichever comes first.

Referto: “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 general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims.

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 client's name and Medicaid number.

2.7.2 Reimbursement Guidelines: Cost Reporting and Interim Claims

During the cost report period, school districts 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. All claims for reimbursement are based on the

actual amount of billable time associated with the SHARS service. 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.

In accordance with the IDEA and the Federal Family Educational Rights and Privacy Act (FERPA), schools 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 prior to billing Medicaid for SHARS services.

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 client at the school do not affect the type or amount of Medicaid services the client receives outside the school setting.

2.7.2.1 Interim Claiming

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

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.

Reminder: 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, $68 \text{ total billable minutes} / 15 = 4 \text{ units} + 8 \text{ minutes}$. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, $68 \text{ total billable minutes} = 5 \text{ units of service}$.

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
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 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 school districts. CMS requires that school districts, 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 federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period.

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.

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 <https://pfd.hhs.texas.gov/acute-care/school-health-and-related-services-shars>. Further information can be found in the Texas Administrative Code, Rule 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.

Referto: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (Vol. 1, General Information) for more information.

Subsection 2.9, "Federal Medical Assistance Percentage (FMAP)" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (Vol. 1, General Information).

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 federal fiscal year (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 federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the date of service and not the date of payment.

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.

Referto: Subsection A.12.4, "TMHP Provider Relations" in "Appendix A: State, Federal, and TMHP Contact Information" (Vol. 1, General Information)" for more information about provider relations representatives.

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.

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