## School Health and Related Services (SHARS)

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42.1 Overview
Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as SHARS. The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allow local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services documented in a student’s Individualized Education Program (IEP). SHARS are provided to students who meet all of the following requirements:

• Are 20 years of age or younger and eligible for Medicaid
• Meet eligibility requirements for special education described in the Individuals with Disabilities Education Act (IDEA)
• Have IEPs that prescribe the needed services

Covered SHARS include:

• Audiology services
• Counseling
• Nursing services
• Physician services
• Occupational therapy (OT)
• Physical therapy (PT)
• Psychological services, including assessments (procedure code 96101)
• Speech therapy services
• Personal care services
• Transportation in a school setting

These services must be provided by qualified personnel who are under contract with or employed by the school district. Furthermore, the school district must be enrolled as a SHARS Medicaid provider in order to bill Texas Medicaid for these services.

Important: The Centers for Medicare & Medicaid Services (CMS) requires SHARS providers to participate in the Random Moment Time Study (RMTS) to be eligible to bill and receive reimbursement for SHARS direct services.

42.2 Enrollment

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 health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(a)(6)(A). 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 health-care 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.

Refer to: “Provider Enrollment” on page 1-3 for more information about enrollment procedures.

42.2.1 SHARS Enrollment
To enroll in Texas Medicaid as a SHARS provider, school districts, including public charter schools, must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS to provide program services. Since public school districts are government entities, they should select “public entity” on the enrollment application.

SHARS providers are required to notify parents/guardians of their rights to a “freedom of choice of providers” (42 Code of Federal Regulations [CFR] §431.51) under Texas Medicaid. Most SHARS providers currently 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 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 SHARS provider and the requested provider do not agree on a contract, the parties can determine whether a nonschool SHARS relationship in accordance with 42 CFR §431.51 is possible. If the parties do not agree to a nonschool SHARS relationship, the SHARS provider is responsible for providing the required services and must notify the parent that no contracted or nonschool SHARS relationship could be established with the requested provider.

Refer to: “Reimbursement Methodology” on page 2-2.

42.2.2 Nonschool SHARS Provider Enrollment

A nonschool SHARS provider must have either a current provider identifier as a Texas Medicaid provider of the IEP service or meet all of the eligibility requirements to obtain a provider identifier as a Texas Medicaid provider of the IEP service. For example, a nonschool SHARS provider of speech therapy must meet all provider criteria to provide Texas Medicaid fee-for-service speech therapy and cannot hold only a state education certificate as a speech therapist.
To be enrolled in Texas Medicaid as a nonschool SHARS provider, the enrollment packet must contain an affiliation letter that:

- Is written on school district letterhead
- Is signed by the school district superintendent or designee
- Contains assurances that the school district will reimburse the state share to HHSC for any Texas Medicaid payments made to the nonschool SHARS provider for the listed student and service
- Lists the Medicaid number and Social Security number of the student to be served and notes the type of IEP
- SHARS service to be provided
- Acknowledges that the nonschool SHARS provider has agreed in writing to:
  - Provide the listed SHARS service shown in the student’s IEP
  - Provide the listed SHARS service in the least restrictive environment as set forth in the IEP
  - Maintain and submit all records and reports required by the school district to ensure compliance with the IEP and compliance with IEP and documentation/billing requirements
- States the effective period for this nonschool SHARS provider arrangement

A separate affiliation letter is required for each Texas Medicaid client to be served by the nonschool SHARS provider. A nonschool SHARS provider is required to have a separate two-digit suffix for each school district with which it is affiliated. For example, if a nonschool SHARS provider has written agreements with Anywhere Independent School District (ISD) for two students and with Somewhere ISD for one student, then the nonschool SHARS provider would submit its claims for the two students from Anywhere ISD under provider identifier 1234567-01 and associated National Provider Identifier (NPI) number if submitting a paper claim. The SHARS provider would submit its claims for the one student from Somewhere ISD under provider identifier 1234567-02 and associated NPI number if submitting a paper claim. The nonschool SHARS provider would submit two affiliation letters from Anywhere ISD to TMHP Provider Enrollment (one for each student served) and one affiliation letter from Somewhere ISD.

Nonschool SHARS providers claims filing is as follows:

Paper claims submissions require an NPI and TPI for the billing and performing provider. The performing and billing provider’s TPI and NPIs must be in the correct associated blocks. If the TPI or NPI is missing from any of the required blocks the claim will be denied.

Electronic claims submissions must be submitted with an NPI only in all NPI related blocks. If a Texas Provider Identifier (TPI) is submitted on an electronic claim, the claim will be denied.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.

“Claims Filing” on page 5-1 for general information about claims filing.
“CMS-1500 Claim Filing Instructions” on page 5-26. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Since nonschool SHARS providers are private, nonpublic entities, they should select “private entity” on the enrollment application.

Nonschool SHARS services include audiology services, counseling services, nursing services, OT, PT, speech therapy services, and psychological services delivered in an individual setting. Nonschool SHARS services do not include evaluation/assessment, physician services, personal care services, or transportation.

42.2.3 Private School Enrollment
A private school may not participate in the SHARS program as a SHARS provider or as a nonschool SHARS provider.

42.2.4 Medicaid Managed Care Enrollment
SHARS providers do not enroll with the Medicaid Managed Care health plans. SHARS providers deliver services to all eligible Medicaid SHARS clients, including clients of the Medicaid Managed Care health plans. SHARS services are not covered by the Medicaid Managed Care health plans. SHARS services that are rendered to clients of Medicaid Managed Care are covered and reimbursed by TMHP. Students who are 20 years of age or younger and on a Medicaid 1915(c) waiver program are covered and reimbursed by TMHP.

SHARS providers should use program code 200 to bill for Primary Care Case Management (PCCM). SHARS providers should use program code 100 to bill for Texas Medicaid fee-for-service.

42.3 Reimbursement

42.3.1 Reimbursement
SHARS providers are cost reimbursed in accordance with 1 TAC §355.8443.

School districts can access their district-specific interim rates on the HHSC website at www.hhsc.state.tx.us/medicaid/programs/rad/AcuteCare/Shars/Shars.html and click on the link titled Click Here To Access The Interim Rates Table.

SHARS providers must participate in and comply with all RMTS requirements to be eligible to bill and receive Medicaid reimbursement for delivering SHARS services. For each annual SHARS Cost Report period (September through August), if a school district does not participate in one of the three required quarterly RMTS, that school district cannot be a SHARS provider for that annual cost report period and will be required to return any Medicaid
payments received for SHARS delivered during that annual cost report period. The school district can return to the SHARS program the following annual cost report period.

New SHARS providers can call the RMTS contracted vendor at 1-888-321-1225.

Refer to: “Reimbursement Methodology” on page 2-2 for more information about reimbursement.

“Federal Financial Participation (FFP) Rate” on page 2-6.

42.3.1.1 Random Moment Time Study (RMTS)

CMS requires existing SHARS providers to participate in the Random Moment Time Study (RMTS) to be eligible to bill and receive reimbursement for SHARS direct services. SHARS providers must comply with the Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Administrative Claiming Effective April 25, 2007, which includes but is not limited to: Mandatory Annual Program Contact training, certification of all RMTS participants for the three RMTS quarters conducted, and compliance with all sampling and participation requirements. The three RMTS quarters are October through December, January through March, and April through June.

Existing SHARS providers that do not participate in one of the three required RMTS quarters or are RMTS non-compliant cannot be a SHARS provider for that annual cost report period and will be required to return any Medicaid payments received for SHARS delivered during that annual cost report period. The school district can return to the SHARS program the following cost report.

New SHARS providers may not bill or be reimbursed prior to the RMTS quarter in which they begin participating in and must participate in all future RMTS quarters.

School districts can access the Texas Time Study Implementation Guide for Direct Medical Services and Medicaid Claiming Effective April 25, 2007 on the HHSC website at www.hhsc.state.tx.us/Medicaid/programs/(rad/AcuteCare/Shars/Shars.html and click on the link titled RMTS Implementation Guide.

SHARS providers can call the RMTS contracted vendor at 1-888-321-1225.

42.3.1.2 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 letter to SHARS providers at the end of each quarter of the federal fiscal year (October 1 through September 30). The purpose of the letter is to verify that the school district incurred allowable costs/expenditures on the dates of service that were funded from state/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 which shows that quarter’s combined total payments for Medicaid fee-for-service claims and Medicaid PCCM claims. For help balancing the amounts in the letter, providers can contact their Provider Relations representative or the TMHP Contact Center at 1-800-925-9126.

Refer to: “TMHP Provider Relations” on page xiv for more information about provider relations representatives.

The Certification of Funds letter 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 letter is received by TMHP. Providers must contact the TMHP Contact Center at 1-800-925-9126 if they do not receive their Certification of Funds letter.

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

42.3.1.3 Cost Reporting

CMS requires the implementation of annual cost reporting, cost reconciliation, and cost settlement processes for all such Medicaid services delivered by school districts. Recent changes from CMS require 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 district-specific interim rates that are as close as possible to each district’s estimated Medicaid-allowable costs for providing each service.

Each SHARS provider is required to complete an annual cost report for all SHARS that were delivered during the previous state fiscal year (September 1 through August 31). The cost report is due on or before March 1 of the year following the reporting period. The next SHARS cost report will cover September 1, 2007, through August 31, 2008, and is due on or before March 1, 2009.

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. The annual SHARS cost report
includes a certification of funds statement which must be completed to certify the provider’s actual, incurred costs/expenditures. All annual SHARS cost reports that are filed are subject to desk review by HHSC or its designee.

42.3.1.4 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. The SHARS cost report is due on or before March 1, 2009, with the cost reconciliation and settlement processes completed no later than August 31, 2010.

If a provider has not complied with all RMTS 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 shall issue a notice of settlement that denotes the amount due to or from the provider.

42.4 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 rather than the five years required by Medicaid. All records that are pertinent to SHARS billings must be maintained by the school district until all audit questions, appeal hearings, investigations, or court cases are resolved. Records should be stored in a readily accessible location and format and must be available for state and/or federal audit.

The following is a checklist of the minimum documents to collect and maintain:
- IEP
- Current provider qualifications (licenses, etc.)
- Attendance records
- Prescriptions/referrals
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Session notes or service logs, including provider signatures
- Supervision logs
- Special transportation logs
- Claims submittal and payment histories
- If applicable, nonschool SHARS provider’s affiliation letter and signed agreement with the district

42.5 Eligibility Verification
The following are means to verify Medicaid eligibility of students:
- Verify electronically through TMHP electronic data interchange (EDI) with 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. 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 the Automated Inquiry System (AIS) at 1-800-925-9126.
- Contact the TMHP Contact Center at 1-800-925-9126.

42.6 Benefits and Limitations
All of the SHARS procedures listed in the following sections require a valid International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code. SHARS include audiology services, counseling, physician services, nursing services, OT, PT, psychological services, speech therapy services, personal care services, and transportation.

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 20 years of age or younger receive the benefits accorded to them by federal and state law in order to participate in the educational program.

42.6.1 Audiology
Audiology evaluation services include:
- 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 habilitation of hearing
- Determination of the child’s need for group and individual amplification
Audiology therapy services include the provision of habilitation activities, such as language habilitation, auditory training, audiological maintenance, speech reading (lip reading), and speech conversation.

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. State licensure requirements are equal to American Speech-Language-Hearing Association (ASHA) certification requirements.

Audiology evaluation is billable on an individual (92506, with modifier U9) basis only. Audiology therapy is billable on an individual (192507) and group (92508) basis. Only the time spent with the student present is billable; time spent without the student present is not billable. 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). 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.

### 42.6.1.1 Audiology Billing Table

<table>
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<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Assistant</th>
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<tr>
<td>1, 2, or 9</td>
<td>92506 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92507 with modifier U9</td>
<td>Individual</td>
<td>Licensed audiologist</td>
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<td>1, 2, or 9</td>
<td>92507 with modifier U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U9</td>
<td>Group</td>
<td>Licensed audiologist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>92508 with modifier U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
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*Place of Service: 1=office/school; 2=home; 9=other locations

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

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time for audiology evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct audiology therapy (group and/or individual) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### 42.6.2 Counseling Services

Counseling services are provided to help a child with a disability benefit from special education and must be listed in the IEP. Counseling services include, but are not limited to the following:

- Assisting the child and/or parents in understanding the nature of the child’s disability
- Assisting the child and/or parents in understanding the special needs of the child
- Assisting the child and/or parents in understanding the child’s development
- Health and behavior interventions 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

Counseling services must be provided by a professional who has one of the following certifications or licensures: a licensed professional counselor (LPC), a licensed clinical social worker (LCSW, formerly LMSW-ACP), or a licensed marriage and family therapist (LMFT).

Counseling services are billable on an individual (96152) or group (96153) basis. Session notes are required and documentation must include the billable start time, billable stop time, total billable minutes, activity performed during the session, student observation, and the related IEP objective.

School districts may receive reimbursement for emergency counseling services as long as the student’s IEP includes a behavior improvement plan that documents the need for emergency services.

### 42.6.2.1 Counseling Services Billing Table

<table>
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<th>POS*</th>
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<td>1, 2, or 9</td>
<td>96152 with modifier UB</td>
<td>Individual</td>
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<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier UB</td>
<td>Group</td>
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</table>

*Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations

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

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time (individual and/or group) is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.
42.6.3 Physician Services
Diagnostic and evaluation services are reimbursable under SHARS physician services. Physician services must be provided by a licensed physician (MD or DO). A physician prescription is required before PT or OT services can be reimbursed under SHARS. Speech therapy services require either a physician prescription or a referral from a licensed speech language pathologist (SLP) before the speech therapy services can be reimbursed under the SHARS program. The school district must maintain the prescription/referral. The prescription/referral must relate directly to specific services listed in the IEP. If a change is made to a service on the IEP that requires a prescription/referral, the prescription/referral must be revised accordingly.

The expiration date for the physician prescription is the earlier of either the physician’s designated expiration date on the prescription or three years, in accordance with the IDEA three-year re-evaluation requirement.

SHARS physician services are billable only when they are provided on an individual basis. The determination as to whether or not the provider needs to see the student while reviewing the student’s records is left up to the professional judgment of the provider. Therefore, billable time includes the following:

- The diagnosis/evaluation time spent with the student present
- The time spent without the student present reviewing the student’s records for the purpose of writing a prescription/referral for specific SHARS services
- The diagnosis/evaluation time spent with the student present, and/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/referral for that service

Session notes are not required for procedure code 99499; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the medical activity that was performed.

42.6.3.1 Medical Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>99499</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = Office/School; 2 = Home; 9 = Other Locations

Providers must use a 15-minute unit of service for billing. Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time is one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.4 Nursing Services
Nursing services are skilled nursing tasks, as defined by the Texas Board of Nursing (BON), that are included in the student’s IEP. Nursing services may be direct nursing care or medication administration. 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
- Tube feeding
- Suctioning
- Client training
- Assessment of a student’s nursing and personal care services needs

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

Nursing services must be provided by an RN, an APN (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 by an RN or APN.

Nursing services are billable on an individual or group basis. Only the time spent with the student present is billable. Time spent without the student present is not billable. Session notes are not required for nursing services; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of nursing service that was performed.

42.6.4.1 Nursing Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier TD</td>
<td>Individual</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1002 with modifier TD-UD</td>
<td>Group</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

*Place of Service: 1 = office/school; 2 = home; 9 = other locations

Modifier TD = nursing services provided by an RN or APN
Modifier U7 = nursing services delivered through delegation.
Modifier TE = nursing services delivered by an LVN/LPN
Modifier UD = nursing services delivered on a group basis
42.6.5 Occupational Therapy

In order for a student to receive Occupational Therapy (OT) through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribed the OT must be provided.

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

OT includes:

- 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

OT must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a certified occupational therapist assistant (COTA) acting under the supervision of a qualified occupational therapist.

OT evaluation is billable on an individual (procedure code 97003) basis only. OT is billable on an individual (procedure code 97530) or group (procedure code 97150) basis. The occupational therapist or COTA 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 are not required for procedure code 97003; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., OT evaluation). Session notes are required for procedure codes 97530 and 97150. 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.

42.6.5.1 Occupational Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97003</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GO-U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

While the procedure code descriptions specifically state “up to 15 minutes,” the Medicaid-allowable fee is determined based on 15-minute increments. Therefore, providers must use a 15-minute unit of service for billing.

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. Do not convert minutes of nursing services separately for each nursing task that was performed.

Minutes of nursing services cannot be accumulated over multiple days. Minutes of nursing services can only be billed per calendar day. If the total number of minutes of nursing services is less than eight minutes for a calendar day, then no unit of service can be billed for that day, and that day’s minutes cannot be added to minutes of nursing services from any previous or subsequent days for billing purposes.

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time for direct nursing services is four hours per day. The recommended maximum billable units for procedure code T1502 with modifier TD, T1502 with modifier U7, or T1502 with modifier TE is a total of four medication administration visits per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

### Medication Administration

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1502 with modifier TD</td>
<td>Medication administration, per visit</td>
</tr>
<tr>
<td>T1002 with modifier U7</td>
<td>Delegation, individual, 15 minutes</td>
</tr>
<tr>
<td>T1002 with modifier U7-UD</td>
<td>Delegation, group, 15 minutes</td>
</tr>
<tr>
<td>T1502 with modifier U7</td>
<td>Delegation, medication administration, per visit</td>
</tr>
<tr>
<td>T1003 with modifier TE</td>
<td>Individual, 15 minutes</td>
</tr>
<tr>
<td>T1003 with modifier TE-UD</td>
<td>Group, 15 minutes</td>
</tr>
<tr>
<td>T1502 with modifier TE</td>
<td>Medication administration per visit</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

Modifier TD = nursing services provided by an RN or APN
Modifier U7 = nursing services delivered through delegation.
Modifier TE = nursing services delivered by an LVN/LPN
Modifier UD = nursing services delivered on a group basis

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.
### 42.6.6 Physical Therapy

In order for a student to receive PT through SHARS, the name and complete address or the provider identifier of the licensed physician who prescribes the PT must be provided.

PT evaluation includes evaluating the student’s ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems.

PT is provided for the purpose of preventing or alleviating movement dysfunction and related functional problems.

PT must be provided by a professional who is licensed by the Texas Board of Physical Therapy Examiners or a licensed physical therapist assistant (LPTA) acting under the supervision of a qualified physical therapist.

PT evaluation is billable on an individual (procedure code 97001) basis only. PT is billable on an individual (procedure code 97110) or group (procedure code 97150) basis. 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), is not billable. Session notes are not required for procedure code 92506; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation). Session notes are required for procedure codes 97110 and 97150. 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.

### 42.6.7 Speech Therapy

#### 42.6.7.1 Referral

The name and complete address or the provider identifier of the referring licensed physician or licensed SLP is required before speech therapy services can be billed under SHARS. A licensed SLP’s evaluation and recommendation for the frequency, location, and duration of speech therapy serves as the speech referral.

#### 42.6.7.2 Description of Services

Speech evaluation services include the identification of children with speech and/or language disorders and the diagnosis and appraisal of specific speech and language disorders. Speech therapy services include the provision of speech and language services for the habilitation or prevention of communicative disorders.

Speech evaluation is billable on an individual (92506 with modifier GN) basis only. Speech therapy is billable on an individual (92507) or group (92508) basis. 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. Session notes are not required for procedure code 92506;

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<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97530 with modifier GO-U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

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### 42.6.6.1 Physical Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>97001</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97110 with modifier GP-U1</td>
<td>Individual</td>
<td>Licensed/certified assistant</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP</td>
<td>Group</td>
<td>Licensed therapist</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>97150 with modifier GP-U1</td>
<td>Group</td>
<td>Licensed/certified assistant</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

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Providers must use a 15-minute unit of service for billing. Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time for OT evaluation is one hour, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

The recommended maximum billable time for PT evaluation is one hour, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.
however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the activity that was performed (e.g., speech evaluation). Session notes are required for procedure codes 92507 and 92508. 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.

42.6.7.3 Provider and Supervision Requirements
Speech therapy services are eligible for reimbursement when they are provided by a qualified speech language pathologist (SLP), who holds a Texas license or an ASHA-equivalent SLP (has a master’s degree in the field of speech language pathology and a Texas license). Speech therapy services are also eligible for reimbursement when provided by an SLP with a state education agency certification, a licensed SLP intern, or a grandfathered SLP when acting under the supervision or direction of an SLP. The supervision must meet the following provisions:

• The supervising SLP must provide supervision that is sufficient to ensure the appropriate completion of the responsibilities that were assigned.

• The direct involvement of the supervising SLP in overseeing the services that were provided must be documented.

• 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 State Board of Examiners for Speech-Language Pathology and Audiology which relate to Licensed Interns or Assistants in Speech-Language Pathology.

CMS interprets “under the direction of a speech-language pathologist,” as an SLP who:

• Is directly involved with the individual under his direction.

• Accepts professional responsibility for the actions of the personnel he agrees to direct.

• Sees each student at least once.

• Has input about the type of care provided.

• Reviews the student’s speech records after the therapy begins.

• Assumes professional responsibility for the services provided.

42.6.7.4 Speech Therapy Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
<th>Therapist or Licensed/Certified Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>92506 with modifier GN</td>
<td>Individual</td>
<td>Licensed therapist</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

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

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable time for evaluation is three hours, which may be billed over several days. The recommended maximum billable time for direct therapy (group and/or individual) is a total of one hour per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

42.6.8 Evaluation/Assessment and Psychological Services

42.6.8.1 Evaluation/Assessment

Evaluations/assessments include activities related to the evaluation of the functioning of a student for the purpose of determining eligibility, the needs for specific SHARS services, and the development or revision of IEP goals and objectives. An evaluation/assessment 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.

Evaluations/assessments (procedure code 96101) 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 34 CFR §300.136(a)(1).

Evaluation/assessment 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/teacher consultation with the student present that is required during the assessment because a student is unable to communicate or perform certain activities

- Time spent without the student present for the interpretation of testing results

Time spent gathering information without the student present or observing a student is not billable evaluation/assessment time.

Occupational therapists, physical therapists, audiologists, and SLPs who perform an evaluation should bill for their time under their individual procedure codes (97003, 97001, and 92506, with modifier U9, or 92506, with modifier GN).

Assessments for visual impairment that are performed by a licensed physician can only be billed under the medical services procedure code 99499. State-mandated vision and hearing screenings are not billable under SHARS.

Session notes are not required; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note which assessment activity was performed (e.g., testing, interpretation, or report writing).

**Evaluation/Assessment Billing Table**

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual/Group</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96101</td>
<td>Individual</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

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:** “Billing Units Based on 15 Minutes” on page 42-14.

When billing, minutes of Evaluations/Assessments are not accumulated over multiple days. Minutes of Evaluations/Assessments can only be billed per calendar day.

The recommended maximum billable time is eight hours (8.0 units) over several days. Time spent for the interpretation of testing results without the student present is billable time. Providers must submit documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

**42.6.8.2 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. Nothing in this rule prohibits public schools from contracting with licensed psychologists and licensed psychological associates who are not LSSPs to provide psychological services, other than school psychology, in their areas of competency. 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 LSSP who is employed by the school district. 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(1)(B).

All psychological services are billable on an individual (96152) or group (96153) basis. Session notes are required. 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.

School districts may receive reimbursement for emergency psychological services as long as the student’s IEP includes a behavior improvement plan that documents the need for the emergency services.

**Psychological Services Billing Table**

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual/Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>96152 with modifier AH</td>
<td>Individual</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>96153 with modifier AH</td>
<td>Group</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

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

**Refer to:** “Billing Units Based on 15 Minutes” on page 42-14.

Important: The recommended maximum billable time for direct psychological therapy (group and/ or individual) is a total of one hour per day for nonemergency situations. Providers must maintain documentation of the reasons for the additional time, if more than the recommended maximum time is billed.

**42.6.9 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 ADLs (IADLs) but may have limitations in performing these activities because of a functional, cognitive, or behavioral impairment. For personal care services to be billable, they must be listed in the student’s IEP. Personal care services are billable on an individual (T1019 with modifier U5 or U6) or group (T1019 with modifier U5-UD or U6-UD) basis. Session notes are not required for procedure codes T1019 with modifier U5 or T1019 with modifier U5-UD; however, documentation must include the billable start time, billable stop time, total billable minutes, and must note the type of personal care service that was performed. Procedure codes T1019 with modifier U6 and T1019 with modifier U6-UD are billed using a one-way trip unit of service.
42.6.9.1 Personal Care Services Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Individual or Group</th>
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</thead>
<tbody>
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<td>1, 2, or 9</td>
<td>T1019 with modifier U5</td>
<td>Individual, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U5-UD</td>
<td>Group, school</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6</td>
<td>Individual, bus</td>
<td>Per one-way trip</td>
</tr>
<tr>
<td>1, 2, or 9</td>
<td>T1019 with modifier U6-UD</td>
<td>Group, bus</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

Refer to: “Billing Units Based on 15 Minutes” on page 42-14.

The recommended maximum billable units for T1019 with modifier U5 or T1019 with modifier U6-UD is a total of four one-way trips per day. Providers must submit documentation of the reasons for the additional time, if more than the recommended units of service are billed.

42.6.10 Transportation Services in a School Setting

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

- Provided to and/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-covered SHARS is included in the student’s IEP
- The special transportation service is included in the student’s IEP

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). A 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. 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

Children with special education needs who ride the regular school bus to school with other nondisabled children are not required to have the transportation services in a school setting listed in their IEP. Also, the cost of the regular school bus ride cannot be billed to SHARS. Therefore, the fact that a child may receive a service through SHARS does not necessarily mean that the transportation services in a school setting would be reimbursed for them.

Reimbursement for covered transportation services is on a 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 district
- From a provider’s office that is contracted with the district to the student’s residence
- From the school to a provider’s office that is contracted with the district
- From a provider’s office that is contracted with the district 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 a Medicaid-covered SHARS service (other than transportation). Documentation of each one-way trip provided must be maintained by the school district (e.g., trip log). This service must not be billed by default simply because the student is transported on a specially adapted bus.

42.6.10.1 Transportation Services in a School Setting Billing Table

<table>
<thead>
<tr>
<th>POS*</th>
<th>Procedure Code</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, or 9</td>
<td>T2003</td>
<td>Per one-way trip</td>
</tr>
</tbody>
</table>

*Place of Service: 1=office/school; 2=home; 9=other locations

The recommended maximum billable units for 1-T2003 is a total of four one-way trips per day.
42.7 Claims Information

42.7.1 Other Insurance

Medicaid guidelines state that other insurance carriers must be billed before billing Texas Medicaid. If the SHARS student has other insurance, the SHARS provider can call the other insurance company to inquire whether the service is covered under the student’s insurance plan. If the service is not covered under the student’s insurance plan, the SHARS provider can obtain from the other insurance company a verbal denial without ever billing the other insurance carrier.

To appeal a Medicaid claim that was denied for other insurance using a verbal denial from the other insurance company, the SHARS provider should submit the following information:

- The date of the telephone call with the other insurance company
- The name and telephone number of the insurance carrier
- The name of the insurance representative
- Policy and group holder information
- The specific reason for denial

Include the client’s type of coverage to improve the accuracy of future claims processing.

If the SHARS provider learns that the other insurance policy does cover the service, the SHARS provider must obtain parental permission to bill the other insurance carrier. If parental permission is not received or the SHARS provider does not wish to pursue payment through the other insurance carrier, the SHARS provider cannot bill Texas Medicaid by submitting claims for the services to TMHP.

42.7.2 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 claim forms from the vendor of their choice. TMHP does not supply the forms.

Electronic claims submissions must be submitted with an NPI only in all NPI-related blocks. If a TPI is submitted on an electronic claim, the claim will be denied.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

NPI is required for all claims. Paper claims submissions require an NPI and TPI for the billing and performing provider. The performing and billing provider’s TPI and NPI must be in the correct associated blocks. If the TPI or NPI is missing from any of the required blocks the claim will be denied.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.
“Claims Filing” on page 5-1 for general information about claims filing.
“Claims Filing Instructions” on page 5-7. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

42.7.3 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.

42.7.4 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

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42.7.5 Billing Units Based on 15 Minutes

All claims for reimbursement 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 (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Reminder: Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will 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:
• 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

42.7.6 Billing Units Based on an Hour

All claims for reimbursement are based on the actual amount of billable time associated with the SHARS service. For those services for which the unit of service is an hour (1 unit = 60 minutes = one hour), partial units should be billed in tenths of an hour and rounded up or down to the nearest six-minute increment.

Reminder: Enter the number of billing units in Block 24G of the CMS-1500 paper claim form. Claims without this information will 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 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:

• 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
Other examples:
• 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