

SCHOOL HEALTH AND RELATED SERVICES (SHARS) FREQUENTLY ASKED QUESTIONS

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This updated document was developed through a cooperative effort between the Texas Education Agency (TEA) and the Texas Health and Human Services Commission (HHSC), with questions submitted from third-party vendors, school districts and shared service arrangements (SSAs). This document reflects the current approved Medicaid SHARS State Plan language effective September 1, 2006. This document is not intended to establish policy, but rather to provide policy clarification and guidance. Additional clarification, interpretations, and answers to questions will be added as the need arises.

For more information on procedure codes, service descriptions, billable time, eligible providers, and documentation requirements, please refer to the **Billing Guidelines** on the TEA SHARS website and the current **Texas Medicaid Provider Procedures Manual (TMPPM)** section on SHARS and the section on Provider Enrollment and Responsibilities.

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A. GENERAL QUESTIONS

A1. What criteria must a child meet in order for the district to bill Medicaid under the SHARS program?

SHARS reimbursement is provided for students who meet all of the following requirements:

- Be enrolled in a public school's special education program;
- Be 20 years of age and younger and eligible for Medicaid
- Have an Admission, Review, & Dismissal (ARD)/ Individualized Education Plan (IEP) documenting the medical necessity for services [Documentation requirements can be found in the current Texas Medicaid provider Procedures Manual (TMPPM), in the Provider Enrollment and Responsibilities Section and in the SHARS Section];
- Have a disability or chronic medical condition;
- Be Medicaid eligible.

A2. Is it required to obtain parental consent in order for the district to bill Medicaid under the SHARS program?

As per the guidelines provided by the Texas Education Agency (TEA), schools should obtain informed parental consent to bill Medicaid for the specific services and the frequency as outlined in the child's current ARD/IEP.

A3. If a child receives Medicaid billable services at school under the SHARS program, are they also able to receive the same service through Medicaid outside of the regular school hours?

Yes, the child's eligibility for, or amount of, Medicaid services outside the school setting is not compromised by receiving SHARS at school. Although all Medicaid services must be medically necessary, the services provided at school under the SHARS program also are necessary for the child to receive a free and appropriate public education. However, due to medical necessity alone, the child may need additional Medicaid services outside of school. For example, a school may provide and bill for SHARS speech therapy for a student who also receives speech therapy from a different Medicaid provider outside the school setting.

A4. Could billing SHARS cause a child to exceed any "cap" or lifetime maximum on their Medicaid benefits?

There is no lifetime benefit cap for Medicaid services to children 20 years of age or younger. SHARS is a program under the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program. Under EPSDT, there are no set limitations or caps on Medicaid services to clients 20 years of age or younger, so long as the services are medically necessary. The Medicaid services the child receives at school do not affect the type or amount of Medicaid services the child receives outside of school.

A5. Will the services received under SHARS impact other Medicaid services prescribed by my primary physician?

The Medicaid services the child receives at school do not affect the type or amount of Medicaid services the child receives outside of school.

A6. What revenue code should be used to account for Medicaid reimbursement (SHARS) in the Financial Accountability System?

School districts should use revenue code 5931 “School Health and Related Services (SHARS).” (**TEA Financial Accountability System Resource Guide, 15.0 – Financial Accounting and Reporting § 1.4.8 Revenue Object Codes**). Medicaid reimbursements received by school districts for SHARS services are considered “vendor” payments and do not require separate accountability for audit purposes. These dollars may be deposited to the General Revenue Fund however, school districts are not allowed to use federal funds as the match for federal Medicaid funds. IDEA funds cannot be comingled with other funds. See [IDEA §1412\(a\)\(17\)\(B\)](#).

TEA Financial Accountability System Resource Guide:

http://tea.texas.gov/Finance_and_Grants/Financial_Accountability/Financial_Accountability_System_Resource_Guide/.

A7. Are there any guidelines in place on how the received funding must be spent?

No, the Medicaid funding that schools receive for delivering SHARS services to special education students is not considered federal money at the school district level and is not subject to the Single Audit Act under OMB A-133. A general guideline is that the money should be spent on services or items to better benefit the program.

A8. Can a SHARS provider provide services beyond the IEP requirements?

No, the IEP authorizes the maximum services that can be provided and billed under the SHARS program. The Individuals with Disabilities Education Act (IDEA), requires school districts to follow the IEP requirements. Any services billed to Medicaid in excess of those stated in the IEP could be subject to recoupment.

A9. Can a federally funded position bill for direct medical services as long as all of the SHARS program requirements have been met?

Providers that deliver SHARS services to a Medicaid client are required to bill for services. In order to bill for the provider, the position will need to be reported on the district’s participant list (PL). In some cases, the provider may be fully or partially federally funded. If the district intends to report any costs associated with delivering the SHARS services, including other allowable costs (such as Appendix A items or specialized transportation) the district is required to bill for those services, regardless of the funding received for the position. The original cost must be claimed through Medicaid in order for any subsequent allowable costs to be

reimbursable. When the cost report is prepared, the district will need to report the provider's federally funded amount in order to offset his/her costs from the total Medicaid allowable costs.

If the district intends to report no other costs associated with the original, federally funded provider's services it is not necessary to bill for the services delivered to Medicaid clients, nor is it required to include the position on the cost report. However, for RMTS requirements, the position may still need to be included on the PL.

A10. How many days from the date of service does a school have to bill for SHARS reimbursement?

A school district must file all claims within 365 days of the date of service or 95 days after the end Federal Fiscal Year (September 30), whichever comes first. A district cannot bill for services delivered before its SHARS provider enrollment date. For example, for dates of service covering October 1 through September 30, all claims must be submitted no later than 365 days from the date of service or January 3 of the following year, whichever comes first.

A11. Can a provider's travel time be billed?

No, travel time for providers may not be billed separately under the SHARS program, only the services listed in the SHARS program rules (§354.1341-1342) are billable at an interim rate. This indirect time (i.e., when the client is not present) is built into a school district's SHARS interim rate and is an allowable cost on the SHARS cost report. So, while travel time is not separately billable, it is reimbursed.

A12. Where can I get information on the new ICD codes as it relates to SHARS?

TMHP maintains a Code Updates webpage with ICD-10 information and resources. The site can be accessed from the link listed below.

<http://www.tmhp.com/Pages/CodeUpdates/ICD-10.aspx>.

For further assistance with ICD-10 codes, please contact the TMHP Contact Center at 1-800-925-9126.

A13. How do I update my district's direct deposit account for the SHARS program?

To update your district's direct deposit account for the SHARS program, you will need to complete an Electronic Funds Transfer (EFT) Information form. The form can be accessed from the link provided below. Instructions for completing the form are included in the document.

http://www.tmhp.com/Provider_Forms/EFT%20Authorization.pdf.

B. DOCUMENTATION REQUIREMENTS

B1. How long do SHARS providers need to keep their records?

SHARS records need to be retained for at least seven years because they are both Medicaid and educational records. Medicaid records must meet federal retention guidelines and, as such, must be maintained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. The federal guidelines governing public education require records to be stored for seven years. SHARS providers must maintain records as outlined in the TMPPM in the Provider Enrollment and Responsibilities Section and the SHARS Section, which meet the federal retention guidelines.

See also response to Question B10

B2. Where must records be kept for audit purposes?

Records must be stored in a readily accessible and secure location and format. If a SHARS audit is conducted, a school district will usually be allowed up to ten business days to provide the requested documentation. SHARS records must be maintained until all audit questions, appeal hearings, investigations, or court cases are resolved. School districts should maintain written procedures regarding the minimum documentation requirements and where those documents are stored.

B3. What records should be maintained?

At a minimum, the following is a suggested checklist of documents related to the SHARS direct services that were provided which should be collected and maintained for SHARS documentation, this is not an all-inclusive list:

- Signed consent to bill Medicaid by parent or guardian
- ARD/IEP documents (medical necessity; examples of SHARS services)
- Attendance records
- Assessment/evaluations
- Current provider qualifications (current licenses and certifications)
- Attendance records
- Written agreements (contract) for contracted service providers
- Required prescriptions or referrals for services
- Medical necessity documentation (e.g., diagnoses and history of chronic conditions or disability)
- Supervision logs
- Session notes or service logs, including provider signatures
- Transportation documentation (daily trip logs; maintenance logs/records; bus documentation; documentation for cost report)
Claims Submittal and Payment Histories (R&S Reports and General Ledger)
- Copies of signed/notarized quarterly Certification of Funds (COF) letters and supporting documentation, including quarterly COF Reports.

In addition, the SHARS Cost Report and all supporting documentation should be collected and maintained for SHARS records.

NOTE: The child's name and Medicaid number should appear on every page of the medical records (see the Provider Enrollment and Responsibilities Section of the current TMPPM). This would include each page of the ARD/IEP document, session notes and service logs, and evaluations.

For detailed instructions regarding specific Cost Report documentation, refer to: <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>.

B4. Should the individual service provider (i.e., speech therapist, LSSP, nurse) or the school district retain all files and records on a child including session notes?

Yes. As the SHARS billing provider, the school district is responsible for maintaining the appropriate SHARS documentation. It is up to the school district where the documents are stored; but, the documents must be readily accessible to submit to the state or to federal auditors upon request. See also the response to Question B2.

B5. What documentation is necessary to bill for contracted services?

The same documentation is required to be maintained by the school district for contracted services as is required if the services were delivered by school employees which would include a copy of the signed contract, copy of current licensure/certification of the contracted provider, and accounting records documenting payment to the contractor. The school district must also maintain all documentation required to bill for SHARS services, including all documentation requirements for services provided by contracted employees. Although the district is ultimately responsible for maintaining the appropriate SHARS Documentation (please refer to question B4), all contracted providers must also follow the guidelines outlined in the TMPPM and maintain records and documentation in accordance with the records retention guidelines provided in the response to Question B1.

Also, refer to the TEA Billing Guidelines, the TEA SHARS website and the current TMPPM section on SHARS and on Provider Enrollment and Responsibilities.

B6. What information must be included in session notes?

- Date of service
- Student's Medicaid number
- Specify whether service is provided in a group or individual setting
- Time the session begins (billable start time)
- Time the session ends (billable stop time)
- Total billable minutes
- Notation as to the activity performed
- Student observation

- Reference to IEP objective
- Reference to medical necessity related to IEP objective

Example:

10/21/04, 555555555, Group, 9:00-9:30, 30 minutes, articulation (s-sound), student actively engaged, IEP objective 1.6.c

For more information, refer to the TEA **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current **Texas Medicaid Providers Procedure Manual (TMPPM)** at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

B7. Which services require session notes?

Audiology therapy, counseling services, psychological services, occupational therapy (procedure codes 97530 and 97150), physical therapy (procedure codes 97110 and 97150), and speech therapy (procedure codes 92507 and 92508). Session notes are a good resource for the history of treatment and continuity of care. HHSC RAD requires that districts maintain all session notes for allowable SHARS services delivered.

For more information, refer to the TEA **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current **Texas Medicaid Providers Procedure Manual (TMPPM)** at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

B8. What documentation is required for assessments and related service evaluations?

Documentation for assessments (i.e., services billable under procedure code 96101) must include:

- billable start time
- billable stop time
- total billable minutes
- notation as to activity performed during session (i.e., direct testing, interpretation/report writing)

Documentation for related services evaluation (PT, OT, Speech, and Audiology) must include:

- billable start time
- billable stop time
- total billable minutes
- notation as to activity performed during session (i.e., direct testing)

For more information, refer to the TEA **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current TMPPM.

B9. Which services require a “service log” instead of session notes?

Nursing services, physician services, and personal care services require a log with the following information:

- billable start time
- billable stop time
- total billable minutes
- notation as to activity performed during session (i.e., medication administration, tube feeding, toileting, etc.)

For more information, refer to the TEA **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current **Texas Medicaid Providers Procedure Manual (TMPPM)** at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.asp X.

B10. Can an electronic signature or signature protected be used to meet the signature requirements for session notes and service logs documents? If so, what are the signature requirements for session notes and service logs documents?

For Medicaid purposes, a school district’s use of electronic records and signatures for SHARS is permissible. As long as the records are accessible to an investigator or auditor and can be reviewed as needed, maintaining the records in electronic format is acceptable from the perspective of documentation adequacy or other audit issues related to Medicaid. Each school district should determine at its own risk what standards are consistent with state and federal electronic requirements.

Electronic Signatures

- SHARS providers must recognize the potential for misuse or abuse
- SHARS providers must apply relevant administrative procedures, standards, and law
- SHARS providers must ensure system and software products are protected
- The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information attested to in the record
- SHARS providers must check with their respective legal counsel regarding alternative signature methods and associated legal concerns

The Texas Education Agency (TEA) advises that it has no additional requirements regarding the submission of electronic data or the use of electronic signatures. The requirement that records are accessible and can be made available to an auditor or a reviewer as needed is, per TEA, sufficient for its purposes.

B11. What type of documentation is required for billing specialized transportation services?

Another billable SHARS service must be provided the same day the specialized transportation service is provided. A transportation log must be maintained

recording one-way trips. IEP documentation must support the medical necessity as to why the student requires the specialized transportation adaptation. In other words, just because a student rides a vehicle that has a specialized transportation adaptation, such as a wheelchair lift, does not result in the school district being able to bill for specialized transportation services for that student unless the student's IEP documents the student's medical need for the wheelchair lift.

B12. If a provider delivers a service to a Medicaid eligible special education student, is he/she required to complete the SHARS documentation for claims submissions?

Yes, if the provider is delivering specialized services and the services are to a Medicaid client, the provider should meet the qualifications listed in the Texas Medicaid Providers Procedures Manual (TMPPM) for the service being delivered and abide by the policy guidelines regarding proper documentation for that particular service.

Note: If there are multiple providers delivering a service in a group setting, each provider does not have to provide documentation for each child. Only one provider needs to record the necessary information required for the type of service being delivered to the students.

C. PRESCRIPTIONS/REFERRALS

C1. Who is authorized to prescribe physical therapy and occupational therapy?

Medical doctors (MDs), doctors of osteopathy (DOs), advanced practice nurses (APNs) with prescriptive authority and physician's assistants are authorized to prescribe physical therapy (PT) and occupational therapy (OT) services in the SHARS program. PT and OT evaluations are not acceptable as a prescription/referral for SHARS PT or OT services.

C2. Who can write a referral for speech therapy?

Effective 9/1/2003, SHARS requirements allow for either a medical practitioner (as outlined in the response to Question C1) or a licensed practitioner of the healing arts to provide the referral for speech therapy. Licensed speech-language pathologists (SLPs) are considered licensed practitioners of the healing arts. The evaluation and recommendation by the SLP may be considered the referral for services.

C3. May the speech evaluation serve as the speech referral?

Yes, if it is clearly documented that the individual who performed the evaluation was a licensed SLP and the evaluation states that speech therapy is required.

C4. Does the student need to be seen by the medical practitioner in order for a SHARS allowable service to be prescribed for him/her?

Whether or not the authorized medical professional sees the student while reviewing records for writing a prescription is left up to the individual's professional judgment. The medical practitioner is ultimately responsible for the services he/she prescribes; and therefore, the decision for the level of review must be left up to the medical practitioner.

C5. May a district bill Medicaid for therapy provided prior to the date of the signed referral/prescription?

No, the school district cannot bill Medicaid before the referral/prescription for the services is signed. However, the school district is required to deliver the service per the IEP requirements in accordance with IDEA.

C6. How often must a referral/prescription for physical therapy/occupational therapy or speech therapy services be obtained?

A prescription is required after the initial assessment and must be renewed at least every three years. If the prescription or referral has an end date, the prescription must be renewed prior to the end date. For example, some physicians will only write a prescription that is valid for one year. In addition, when there is a change in the plan of care, a new referral/prescription is needed.

C7. What type of change to the IEP would necessitate a new prescription or referral?

Determinations concerning the need for new prescriptions or referrals are decisions made by the student's ARD committee. In addition, when there is a change in the plan of care, a new referral/prescription is needed. For example, if the duration time for treatment sessions change or the number of sessions per week change, a new prescription/referral is needed.

C8. If the goals/objectives change for an OT/PT student from year to year, but the frequency & duration of service does NOT change, is a "new" prescription required?

No. A new prescription is not required.

D. PARENTAL NOTIFICATION

D1. Are schools required to obtain parental consent prior to billing Medicaid for SHARS services?

Yes, according to federal rule 42 CFR §300.154 districts are required to obtain parental consent. More guidance on this issue may be found at <http://idea.ed.gov/explore/view/p/.root,regs,300,B,300%252E154>.

D2. Is it required to obtain parental consent in order for the district to bill Medicaid under the SHARS program?

Schools must obtain parental consent to bill Medicaid for the specific services and the frequency as outlined in the child's current ARD/IEP.

D3. Ideally, the parent will sign the parental consent form at the time of the ARD meeting. If the parent does not attend the ARD, can the district contact the parent by mail or phone?

Because the consent must be written, a phone call could only be used as a means for arranging an alternative time to sign the consent.

D4. If a district sends a parent the Medicaid consent form to sign by mail because he/she did not attend the ARD meeting, but the form is never signed and returned to the district by the parent, has the district done its part to inform the parent? In this scenario, would the district be allowed to submit claims for reimbursement?

No, the burden is on the district to obtain the parental consent form as required by IDEA. If the consent form is not obtained the service and the associated cost is a disallowed cost.

D5. In addition to asking parental permission to bill Medicaid for student-specific services, do you have any suggestions on what to include in the letter?

It may be reassuring to let parents know that:

- billing Medicaid is not a new process
- SHARS is reimbursement money to the schools
- their child's ability to receive services outside of the school setting will not be impacted
- SHARS is a program under EPSDT and is not subject to any type of limit or "cap" on services
- they can withdraw permission at any time

E. FREEDOM OF CHOICE/NONSCHOOL SHARS PROVIDERS

E1. Do school districts need to send a parent notification letter informing parents/guardians of their right to choose a provider?

Schools districts must notify parents of their right to freedom of choice of providers under the Medicaid program (please refer to section 3.2.1 of the TMPPM for more detail). That notification does not have to be a letter or be in writing. Most schools notify parents either through discussions or a written notice during the initial ARD meeting.

E2. Who can be a non-school SHARS provider?

If a parent requests a provider other than the employees or currently contracted staff of the school district, provide a required service listed in the student's IEP, the district must make a good faith effort to comply with the parent's request. The requested provider must meet, comply with, and provide all the employment criteria and documentation that the SHARS provider normally requires of its employees or currently contracted staff. The district 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.

F. RATES

F1. Who set the unrestricted indirect cost rate at the time the rates were developed? If we still do not have one, how do we obtain one?

The Texas Education Agency is responsible for setting the unrestricted indirect cost rate (UIDCR). Districts must submit the required documentation to TEA within the required timeframes to obtain a UIDCR.

F2. Who sets the SHARS interim rates used for interim SHARS payments?

HHSC's Rate Analysis Department (RAD) establishes the SHARS interim rates.

F3. How were the SHARS interim rates developed?

Rates are based on actual costs reported and certified as correct by the districts in the cost report. Total salary information is obtained from the cost report data for all allowable SHARS direct services and transportation.

F4. When are the rates updated?

SHARS interim rates are subject to review by HHSC on a biennial basis and are based on actual cost report data.

HHSC may also adjust rates to compensate for anticipated changes in laws, regulations, policies, guidelines, economic factors or implementation of federal or state court orders or settlement agreements.

F5. Where can I locate a listing of modifiers for SHARS?

All the SHARS procedure codes (with modifiers) are available on the current interim rates table, available on the website below.

<http://legacy-hhsc.hhsc.state.tx.us/rad/acute-care/shars/2017-pmt-rate-alert.html>

Modifiers are also referenced throughout the Texas Medicaid Providers Procedure Manual: Children's Services Handbook (Volume 2) – Section 3, Please visit the website below for further guidance.

http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_ProviderManual_Current.aspx.

F6. Who do I contact if I have questions regarding the SHARS interim rates?

You may contact the SHARS Rate Analyst at:
(512) 730-7400 or ra_shars@hhsc.state.tx.us.

G. QUARTERLY SHARS TIME STUDY

G1. Why do districts have to participate in the SHARS time study process?

The federally approved SHARS State Plan language requires that providers submit an annual cost report, with cost reconciliation and cost settlement processes. The State Plan language also requires that providers must participate in the time study in order to bill for SHARS. The results of the time study are the basis for the calculation of the direct services percentage that is used during the cost reporting process to allocate costs to the Medicaid program.

Participation in the time study means that providers must certify their time study participant list for each quarterly time study by the specified date and must ensure that sampled participants submit responses to sampled moments within seven days of the sampled moment.

G2. How do we determine what staff (including contractors) to include on our participant list to Fairbanks?

- All staff will be reported into one of two staff pools:
 - a “Direct Service and Administrative Providers” staff pool or
 - an “Administrative Services Provider Only” staff pool.
- Each district must certify that its list of staff being submitted for inclusion in each eligible staff pool are appropriate for participation in the time study and for the SHARS program or the Medical Administrative Claiming (MAC) program. Staff that are deemed inappropriate during review of time study quarters will be removed from the time study and excluded from the SHARS cost report and/or the MAC claim.
- A replacement provider can take the place of a person on the certified participant list. If a sampled participant is out on extended leave for more than 51% of the quarter, then a substitute may respond to the moment for the selected employee that is not available. For example, Provider A is on the certified participant list and is replaced temporarily by Provider B during a time study quarter, Provider B may respond in Provider's A place if Provider A is out for more than 51% of the quarter.

- Vacant positions that are anticipated to be filled during the quarter should be included on the participant list.

Direct Service and Administrative Provider List

Providers of SHARS must be reported in the "Direct Services and Administrative Providers" pool.

No transportation (drivers or mechanics)

Provider Category	SHARS Category of Service
Nurses (RNs, LVNs, LPNs)	Nursing Services
Nurse Practitioners (Advanced Practice Nurses (APNs), Clinical Nurse Specialists and Pediatric Mental Health Nurses)	Nursing Services or Physician Services
Delegated Nursing Services Provider (e.g., clinic aides, home health aides, school health aides, certified nurse aides, certified medication aides)	Nursing
Licensed Audiologists and Licensed Audiologist Assistants	Audiology and Hearing Services
Psychologists, including LSSPs	Psychological Services - Assessments and/or Treatment Services
Therapists (Occupational, Physical, Speech)	Occupational Therapy; Physical Therapy; Speech and Language Services
Licensed/Certified Therapy Assistants (COTA, LPTA, SLPA)	Occupational Therapy; Physical Therapy; Speech and Language Services
Licensed Marriage & Family Therapists	Counseling Services
Social Workers only LCSWs, unless they provide PCS for which they should be reported under Personal Care Services	Counseling Services
Personal Care Services – e.g., Special Education Teacher; Special Education Teacher's Aide; Bus Aide/Monitor; Orientation & Mobility Specialists; Sign Language Interpreters; Translators	Personal Care Services
Physicians (MDs/DOs), including Psychiatrists	Physician Services
Physician Assistants	Physician Services

Administrative Services Only Provider List (MAC Services)

If providers in any of the following categories provide Personal Care Services or Delegated Nursing Services, they must be reported on the Direct Service and Administrative staff pool.

Administrative staff such as executive directors, program directors, principals, assistant principals, special education directors, and other managers/supervisory staff are not to be included in the time study, unless they provide billable SHARS delegated nursing or personal care services tasks. Likewise, there should be no clerical or administrative support staff included, again, unless they provide billable SHARS delegated nursing or personal care services tasks.

Provider Category
Behavioral Counselor
Outreach Workers
Service Coordinators/Case Managers
Interpreters/Translators/Bilingual Specialists
Pregnancy Education and Parenting Program (PEP)
Orientation & Mobility Specialist (O&M)
Physician Assistant (PA) <ul style="list-style-type: none"> If these providers bill for Physician Services under SHARS, they must be reported in the Physician category in the Direct Service and Administrative staff pool.
Licensed Bachelors of Social Work (LSW)
Licensed Masters of Social Work (LMSW)
Psychology Intern

G3. Can the same person be designated MAC and SHARS on the RMTS Participant List?

Yes, in order to be claimed on the MAC financials and SHARS cost report (and billable for SHARS to TMHP), the individual would need to be reported under the "Direct Services and Administrative Cost Pool" on the participant list.

G4. We have a contracted Orientation & Mobility Specialist (O&M) as MAC on the PL and we are also billing for the position as direct medical services for PCS. Is this allowed?

If the O&M Specialist was reported on the PL under the Administrative Services Only Cost Pool this is not allowable. If the position was reported under the Direct Services and Administrative Cost Pool this would be allowable.

G5. How often will I need to submit a participant list? Do I need to do a totally new list every time?

The Participant List (PL) can be updated at any time throughout the quarter prior to the time study quarter for which the PL is submitted. The PL should be updated as often as necessary, i.e., as new staff that will be/were included in the time study are hired or leave. If staff does not change in a quarter, the school district does not need to make PL changes. HOWEVER, every federal quarter, even if there have been no staffing changes from the previous quarter, school districts must certify their PL no later than the specified due date.

- G6. We have a School Counselor, who is TEA/SBEC certified, that has gone through further training with our local ESC to have a certificate as a Behavior Specialist. Will she be eligible on the PL?**

Behavior counselors that are strictly behavior counselors are only allowable as MAC providers and should be listed as Administrative Services Only on the district's PL. If the behavioral counselor also provides personal care services (PCS) for the district's SHARS program, he/she can be included on the PL under the Direct Services and Administrative cost pool. In the latter case, the position would be reported as a personal care services provider, not a behavioral counselor.

- G7. If I have questions about the time study process, who should I contact?**

HHSC Rate Analysis Department, Time Study Unit:
Telephone: (512) 490-3194
E-Mail: TimeStudy@hhsc.state.tx.us

Website: <http://www.hhsc.state.tx.us/rad/time-study/ts-isd.shtml>

- G8. Who are the MAC contacts?**

HHSC Rate Analysis Department, MAC Unit
Telephone: (512) 462-6200
E-Mail: MAC@hhsc.state.tx.us

Website: <http://www.hhsc.state.tx.us/rad/mac/isd-mac.shtml>

- G9. Who are the SHARS contacts?**

HHSC Rate Analysis Department, SHARS Unit
Telephone: (512) 730-7400
E-Mail: RA_SHARS@hhsc.state.tx.us

Website: <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>

H. 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 school district 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.

H1. Why do districts have to certify the total 100% instead of just the state share?

Per the Centers for Medicare and Medicaid Services (CMS) and effective 10/1/06, school districts must certify that the school district spent an amount equal to or greater than the Total Computable Expenditure (i.e., both the federal and state/local shares) for the service. The SHARS services are reimbursed only the federal share and the school district is required to provide the state/local match.

Total computable expenditures must meet the definition of Medicaid-allowable costs. The Medicaid-allowable costs are direct payroll costs (i.e., salaries/wages, payroll taxes, employee benefits, and contracted compensation) for employees and contracted staff delivering SHARS.

H2. What is the purpose of the quarterly COF letter?

The purpose of the COF letter is to verify that the school district incurred the 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.

H3. Who can sign the quarterly Certification of Funds letter?

The school district's Business Officer and/or Financial Representative who is responsible for signing other documents subject to audit can sign the quarterly COF letter. The quarterly COF letter must be notarized.

For more information, refer to the SHARS section of the current TMPPM.

H4. What is the difference between quarterly Certification of Funds letter and the Cost Report Certification?

The quarterly COF letter applies to the interim payments received during the previous federal fiscal quarter regardless of the SHARS dates of service. While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior.

The Cost Report Certification is required when submitting the annual SHARS cost report. It is used to formally acknowledge that the cost report is true, correct and complete, and was prepared in accordance to all rules and regulations.

H5. What happens if I don't get my COF letter in on time?

If the initial COF letter is not completed and signed by the school district and received at Texas Medicaid & Healthcare Partnership (TMHP) by the deadline, a second COF letter will be sent with a due date of 10 calendar days later. If the second COF letter is not completed and signed by the school district and received at TMHP by the deadline, HHSC will be notified and the district will be sent a REFERRAL letter that is mailed via certified mail return receipt. If the REFERRAL letter is not completed and signed by the school district and received by TMHP the date specified in the cover letter, a vendor hold will be placed on the provider's

payments until such time as the COF letter is completed and signed by the school district and received at TMHP. At any time the school district can contact TMHP at 1-800-925-9126 to request a copy of their COF letter.

I. ANNUAL COST REPORT PROCESS

11. Is my district 'eligible' to submit a SHARS Cost Report?

In order to be eligible to submit a SHARS cost report, an ISD must:

- Be enrolled and approved for participation as an active Medicaid provider for SHARS with the Texas Medicaid & Healthcare Partnership (TMHP);
- Have an active Texas Provider Identifier (TPI) and National Provider Identifier (NPI);
- Ensure that SHARS services are provided by approved/qualified providers as referenced in the Texas Medicaid Provider Procedures Manual (TMPPM);
- Meet Texas Education Agency (TEA) standards for the delivery of SHARS;
- Abide by Health & Human Services Commission (HHSC) and TEA rules and regulations;
- Meet all eligibility requirements and participate in the Random Moment Time Study (RMTS);
- As services are delivered, bill/claim for SHARS allowable services covered by the TMHP; and
- Have a trained SHARS Financial Contact.

12. Is my district 'required' to submit a SHARS Cost Report?

If the district has met all eligibility and participation requirements, the district must submit an annual SHARS Cost Report. Failure to comply will result in recoupment of all interim SHARS payments received for the year in which the default occurs. The SHARS program is governed by the following rules in the Texas Administrative Codes:

- SHARS program rules (eligibility and participation requirements) are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 354, SubChapter A, Division 25, Rules 1341-1342.
- SHARS reimbursement rules (cost reports and rates) are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443.

SHARS providers who are members of a cooperative or shared services arrangement (SSA) must each submit a separate SHARS Cost Report.

13. What months are covered by the SHARS Cost Report Period?

Texas Health and Human Services Commission (HHSC) requires the SHARS Cost Report reporting period to be a federal fiscal year (FFY) of October 1 through September 30.

14. When is the SHARS Cost Report due date?

The SHARS cost report is due on or before April 1, following the end of the respective SHARS cost report period (October 1 through September 30).

15. What happens if the district is unable to meet the April 1 deadline to submit the SHARS Cost Report?

Failure to file a complete and acceptable cost report by the cost report due date will result in recoupment of all interim SHARS payments for the year in which the default occurs.

16. Can an extension be requested if a district is unable to complete the SHARS Cost Report by April 1?

Yes, written requests for an extension must be received at least 15 working days prior to the original cost report due date, allowing 10 working days for HHSC staff to make a written response. The extension request must clearly explain the necessity for the extension and specify the extension due date being requested. Extension approvals will be granted on a case by case basis and only for good cause. 'Good cause' refers to extreme circumstances that are beyond the control of the provider and for which adequate advance planning and organization would not have been of any assistance. Not being aware of the due date, inconvenience of the due date, the preparer being engaged in other work so the cost report cannot be completed, or the preparer or signer not being available to sign the cost report do not meet the criteria for good cause and are not acceptable reasons to grant an extension of the due date for submission of the cost report.

17. Is SHARS Cost Report Training mandatory?

Yes, SHARS cost report training, held annually, is mandatory. Preparers must successfully complete the SHARS cost report training in order to receive full-access credit to the SHARS Cost Report. Preparers that successfully complete the training in the odd-year, will receive full-access training credit for both that odd-year cost report and the following even-year cost report. However, preparers that successfully complete the training in the even-year, will receive full-access training credit for only the even-year cost report.

HHSC offers training each year for providers to meet training requirements. Only trained individuals will have access to make changes in the cost report system, all individuals that have not met the cost report training requirement will have view-only access.

18. Who is required to go to SHARS Cost Report training?

At minimum, the SHARS Financial Contact who will prepare the online SHARS Cost Report must attend training. The cost report training is also available and recommended for staff: certifying the cost report and certification of funds forms; compiling the Individual Education Plan (IEP) and one-way trip ratios; and Random Moment Time Study (RMTS) program contacts/staff.

19. Who can be assigned as a SHARS Financial Contact?

A SHARS Financial Contact or “preparer” may be a contractor/designee, which includes district staff, SSA staff, Co-Op Fiscal Agents, and/or a Vendor. However if staff from the SSA or a vendor assist the district in preparing the cost report, the person signing the two cost report certification forms must be the member district's Chief Financial Officer (CFO), Business Officer, Superintendent, or other official that has signatory authority for the district.

It is required that the “Primary” SHARS Financial Contact be an employee of the district. Each district is responsible for the designee’s actions and/or non-action. Districts must document the authorization of the designee, clearly specifying the services to be provided by the designee. Districts must provide documentation of such authorization if requested. HHSC recommends that any authorization to enter the cost report data into the cost report system be incorporated into the contract with the authorized entity/designee.

110. When will cost report training occur?

Cost report training sessions are held in January, February and March of each year.

111. How do I submit my cost report?

SHARS providers are required to prepare and submit an annual cost report using a web-based system known as the State of Texas Automated Information Reporting System (STAIRS). The system is provided at no charge by the HHSC Rate Analysis Department and its contractor, Fairbanks, LLC. Cost report instructions and training materials are available on the HHSC Rate Analysis SHARS website.

For questions and assistance with the cost report you may contact the SHARS Rate Analyst(s) at: (512) 730-7400 or ra_shars@hhsc.state.tx.us.

112. Why is the SHARS Cost Report system asking for the fiscal agent’s contact information?

If the district is a member of an SSA/Cooperative it is important that the fiscal agent contact information be completed. The contact should be the name of the person that can provide answers to cost report questions regarding the allocation of time and costs for shared employees. The purpose of tracking this information is to assist in the facilitation of the desk review process.

I13. Why is the system asking for the vendor’s contact information?

If the district has contracted SHARS billing, it is important that the contact information for the vendor be completed. The contact should be the name of the person than can provide detailed answers to questions regarding the time and costs for employees and other costs reported on the cost report. The purpose of tracking this information is to assist in the facilitation of the desk review process.

I14. My district is a member of a Shared Service Arrangement/Cooperative (SSA/Co-Op). If the SSA/Co-Op provided the services and billed for the students enrolled in my district, is my district, as a member district, still required to submit a SHARS Cost Report?

Districts who are members of a cooperative or shared service arrangement must each submit a separate SHARS Cost Report in order to retain the federal dollars claimed for students enrolled in the member district.

I15. My district is the fiscal agent of a SSA/Co-Op. Can the fiscal agent claim costs for all students that the SSA/Co-Op served during the cost report period?

No, the fiscal agent can only report costs for the students enrolled in the district serving as the fiscal agent. All shared costs must be allocated to each of the member districts.

For example, if a member district contributed 15.75% of their expenditures, that district would be allocated 15.75% of the paid hours and payroll costs for each staff person, as well as 15.75% of any other allowable direct costs.

I16. My district is a member of a SSA/Co-Op. How do I know what my shared costs are for the SHARS Cost Report?

The SSA/Co-Op fiscal agent is responsible for allocating each member district's costs as appropriate.

For example, if a member district contributed 15.75% of their expenditures to the SSA/Co-Op, that district could be allocated 15.75% of the paid hours and payroll costs for each staff person, as well as 15.75% of any other allowable direct costs.

Allocation of salary costs based on actual expenditures is another example of how a fiscal agent may choose to allocate salary costs. Additional allocation methodologies used to distribute shared costs to member districts of an SSA/Co-Op must be documented and presented to HHSC, if requested.

I17. Can the SHARS Financial Contact for the SSA/Co-Op fiscal agent prepare the cost report for member districts in an SSA/Co-Op?

Yes, a SHARS Financial Contact or “preparer” may be a contractor/designee, which includes district staff, SSA/Co-Op Fiscal Agents, and/or a Vendor. It is required that the “Primary” SHARS Financial Contact be an employee of the district. HHSC

recommends that any authorization to enter the cost report data into the cost report system be incorporated into the contract with the authorized entity/designee. Each district is responsible for the designee's actions and/or non-action. Districts must document the authorization of the designee, clearly specifying the functions to be performed by the designee.

If staff from the SSA/Co-Op or a vendor assists the district in preparing the cost report, the person signing the two cost report certification forms must be the member district's Chief Financial Officer (CFO), Business Officer, Superintendent, or other official that has signatory authority for the district.

118. What does cost allocation methodology mean and how is it used in the SHARS Cost Report?

Cost is allocated using statistics that have been approved by CMS to facilitate the identification of cost associated with Medicaid. There are four key allocation methods used in the SHARS cost report: (1) an allocation method to identify the cost of medical services irrespective of payer and administrative cost; (2) a method for allocating direct medical services costs to the Texas Medicaid program; (3) a method for allocating transportation costs that cannot be direct costed to specialized transportation services; and (4) a method for allocating specialized transportation one-way trip ratio.

1. The first allocation method is the direct services time study percentage, which reports the amount of time related to all medical services and Medicaid administrative claiming. HHSC provides this number to providers based on a statewide time study.
2. The second allocation method is the ratio of Medicaid covered students with medical IEPs to all students with medical IEPs. Medical IEPs refers to students with IEPs that document the medical necessity for a direct medical service.
$$\text{IEP Ratio} = \frac{\text{The total number of Medicaid students with IEPs requiring medical services}}{\text{The total number of students with IEPs requiring medical services}}$$
3. The third allocation method used in this cost report is for transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or bus mechanic costs. If costs cannot be direct costed to specialized transportation services, it is acceptable to allocate the costs to specialized transportation services based on the number of specialized transportation vehicles divided by the total number of transportation vehicles.
4. The fourth allocation method is the ratio of one-way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one-way specialized transportation trips.
$$\text{One-way trip ratio} = \frac{\text{total one-way trips for Medicaid students with IEPs requiring specialized transportation services}}{\text{Total one-way trips for all students with IEPs requiring specialized transportation services}}$$

I19. How do I get the count for the IEP ratio?

IEP Ratio = (The total number of Medicaid students with IEPs requiring medical services)/(The total number of students with IEPs requiring medical services).

I20. If a student receives a direct medical service and the school district fails to bill for the interim reimbursement, would that student still be counted in the IEP Ratio, provided all other criteria are met? Maybe parent did NOT give consent or district just missed billing for the student, or we failed to uncover Medicaid eligibility, etc.

The IEP ratio is a Medicaid vs. Non-Medicaid student count. A student's inclusion in the numerator of the IEP Ratio is not dependent on whether the district billed for Medicaid services provided to the student. Rather, it is dependent on the student's Medicaid eligibility. If the student was Medicaid eligible during the reporting period, he or she should be included in the numerator as well as the denominator of the IEP Ratio. If the student was not Medicaid eligible during the reporting period, but did have an IEP for one or more direct medical services during the cost reporting period, he or she should only be included in the denominator.

I21. For the IEP Ratio, am I only to count those students with an IEP who were Medicaid eligible AND had a claim filed?

See response to Question I20.

I22. How do I get the one-way trip ratio?

One-way trip ratio = (total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(Total one-way trips for all students with IEPs requiring specialized transportation services)

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle. A specially adapted vehicle is one that has been physically modified (e.g. wheelchair lift). The medical need for the special adaptation must be documented in the student's IEP. One-way specialized transportation trips can only be counted on the days when the student used the specialized transportation and the medical services pursuant to an IEP were provided.

I23. Can I only count the one-way trips to and from the direct service for each student?

No. If the student receives a billable SHARS service (including personal care services on the bus) and is transported on a specially adapted vehicle, the following one-way trips may be claimed:

- 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

A specially adapted vehicle is one that has been physically modified (e.g. wheelchair lift). The need for the special adaptation must be documented in the student's IEP. One-way specialized transportation trips can only be counted on the days when the student used the specialized transportation and the medical services pursuant to an IEP were provided.

I24. If a student meets the criteria for Specialized Transportation, but the district fails to bill for interim reimbursement for those trips, would those trips be counted in the Trip Ratio?

Yes, the unbilled trips would be counted in the ratio. See also response to I21.

I25. Can all specially adapted vehicles (including cars, suburbans, vans, etc.) used by the school district be counted for the SHARS Cost Report or are costs limited only to buses?

Yes. Other vehicles, not only buses, count as long as the vehicle in question meets the definition of "specially adapted."

A specially adapted vehicle is one that has been physically modified (e.g. wheelchair lift). The need for the special adaptation must be documented in the student's IEP. One-way specialized transportation trips can only be counted on the days when the student used the specialized transportation and the medical services pursuant to an IEP were provided.

For more information on specially adapted vehicles refer to the **Texas Medicaid Providers Procedure Manual (TMPPM) – Children’s Services Handbook, Section 3.3.10 Transportation Services in a School Setting** at: http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

I26. Are bus cameras an allowable cost in the SHARS Cost Report?

No, they are not an allowable cost. They are neither direct medical supplies nor necessary to provide transportation services.

I27. How are stipends reported on the cost report?

Since stipends are subject to payroll taxes, they should be included with the employee's other salary amounts and reported as salaries on the cost report.

I28. Which direct medical staff's paid hours and costs can be reported on the cost report?

The Random Moment Time Study (RMTS) Participant List is a critical step in allocating costs and ensuring the district remains eligible to receive SHARS reimbursement. Each service provider reported on the cost report must have been included on the RMTS Participant List in the quarter(s) for which their costs are being claimed. STAIRS has pre-populated each district's cost report with staff information from each district's certified RMTS participant lists for the October through December, and January through March, April through June time studies.

- If there were any "vacant" positions listed on the participant list, those vacant positions will need to be edited to include the replacement staff person's information.
- If member districts of an SSA/Cooperative incorrectly described the shared staff as employees on the participant list that information will need to be edited to reflect "contracted" staff.
- If you have staff performing direct medical services during the "summer school session", the position must be identified on the participant list in order to bill for services and report cost.

I29. Can a district add a position to the cost report?

The State of Texas Automated Information Reporting System (STAIRS) allows cost report preparers to edit positions that were migrated to a district's cost report from its participant list, but does not allow prepares to add new positions.

I30. If a provider was reported multiple times on a district's participant list in error and thus appears on the cost report multiple times, what would be the proper way to record the position's costs? Would the costs need to be split amongst the multiple entries?

Please enter the total individual cost under one name and document in your records the issue.

I31. What paid hours should be reported?

If payroll costs are being reported for a staff person for the entire reporting period, then the paid hours would be those paid for that person for the entire reporting period. If payroll costs are only being reported for a staff person for the period of 9/1 through 3/31, then the paid hours for that staff person would be those for the period covering 9/1 through 3/31.

I32. Does a district have to report its payroll costs for direct medical services staff by entering each individual staff person?

No. Each district can choose to report such payroll costs on an individual staff basis (Step 3A) or on a staff category basis (Step 3B).

Staff category basis means PTs, LPTAs, APNs/RNs, LVNs/LPNs, delegated nursing providers, personal care services providers, counselors, physicians, audiologists, audiologist assistants, OTs, COTAs, psychologists, SLPs, and SLP Assistants.

Note: Employees and contracted staff need to be reported separately in each category.

I33. Can I report medical and dental fringe benefits together on the cost report?

Medical and dental fringe benefits should be reported separately on the cost report.

I34. Although the program is advertised as a self-funded plan, can TRS Active Care contributions be reported as Health Insurance costs on the SHARS Cost Report?

Yes. Per CMS, "if the program is actually a commercial policy with various premiums being made, as opposed to a self-insure arrangement, to the extent the costs are attributable to Title XIX in proportion to the FTE's allocation to Title XIX, then the cost would be appropriate to include in the respective school districts' cost report(s)." This policy change is to be effective with the FFY 2017 SHARS Cost Report.

I35. Can TRS "on behalf of" retirement payments be reported?

No. Only costs that were actually incurred by the school district can be reported.

I36. What costs can be reported for Reimbursing Employers for state unemployment?

A school district cannot report on the cost report the amounts that it sets aside each month for payment of unemployment claims. Only the amounts actually paid for claims for people listed on the cost report are allowed to be reported as costs on the cost report for a reimbursing employer.

I37. What costs can be reported for self-insurance for worker's compensation?

If a school district has a third-party entity administering its self-insurance plan for worker's compensation, the school district can report as worker's compensation costs the portion of the administration costs applicable to the people listed on the cost report, as well as any costs associated with actual claims paid out for the people listed on the cost report. The school district cannot report as costs on the cost report the amounts contributed to the self-insurance plan, since those costs do not represent actual amounts paid out.

138. Our workers compensation insurance costs, paid to a third party, are based on total payroll costs, why would we allocate the cost for the cost report by number of employees?

You can utilize total payroll cost allocation, but ensure that it represents true payments made for insurance. If your insurance program is a partially self-insured program, then you will need to utilize direct costing allocation.

139. If a district has proper IEP documentation and did have costs associated to a billable service area, but does not bill for that particular service area, will the state disallow their costs? For example, a district provided speech services based on services prescribed in a student's IEP, but was unable to bill for the services due to parental consent, would the costs associated with it will be disallowed?

It is the district's responsibility to abide by HHSC rules and regulations and meet Texas Education Agency (TEA) standards for the delivery of SHARS. The individuals with Disabilities Education Act (IDEA) requires parental consent in order to conduct an initial evaluation to determine special education eligibility as referenced in 34 C.F.R. § 300.300(a) (1) (i). IDEA also requires that a public agency obtain parental consent before accessing the child's or parent's public benefits or insurance for the first time. 34 CFR §300.154(d)(2)(v).

If the provider delivered a service to a Medicaid client, that service must be billed through the Texas Medicaid & Healthcare Partnership (TMHP) billing system in order for the school district to receive an interim payment for the service. If an audit is conducted and determined that a provider delivered services to Medicaid clients and did not bill for the services, an auditor may consider extrapolating the cost based on findings resulting in a disallowance in a portion of the cost. It is essential that if a service is delivered to a Medicaid client, that the service must be billed through the TMHP billing system.

140. What "other" direct medical services can be reported?

Staff travel costs to provide direct medical services, required continuing education costs, other direct medical services materials and supplies (from Appendix A), and depreciation - other direct medical services equipment.

141. Where can I find Appendix A?

To view **Appendix A** refer to the SHARS Guides/Manuals section at: <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>.

142. Can costs for other direct medical services materials and supplies be reported?

Yes. However, the only costs for other direct medical services materials and supplies that can be reported are those specifically approved by CMS and listed in Appendix A of the cost report instructions.

To view **Appendix A** refer to the SHARS Guides/ Manuals section at:
<http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>.

- I43. A district has an expense for an on-line continuing education program for special needs students functioning below grade level, what specific description on the Appendix A list does this fall within?**

Continuing education is an educational cost, not a direct medical service supply or material and therefore is not an allowable Appendix A expense.

- I44. Can costs for other direct medical services materials and supplies that are shared with the general student population be reported?**

Yes. However, the only costs for other direct medical services materials and supplies that can be reported are those specifically approved by the Center for Medicare and Medicaid Services (CMS) and listed in Appendix A of the cost report instructions. Appendix A is an all-inclusive list of the only allowable direct medical service supplies and materials approved by CMS. The total cost of Appendix A items reported is allowable if the materials and supplies are only dedicated to the provision of direct medical services. **For example, computer software, hardware, including computers and word processors, and assistive technology software total cost is allowable only if the items are utilized for specialized services, such as for clinical evaluations and instructional software.**

Data Entry Tip: Many of the cost reports steps for the cost report no longer require data to be entered sequentially. However, when entering information into the cost report system and detailed data is not available for a particular step (example: IEP or one-way trip counts), the cost report system will accept a zero entry. Zero entries will result in a "green checkmark" and the step can then be temporarily bypassed and revisited later. **If you bypass a step, please remember to go back to each step to ensure all data has been corrected before submitting the cost report.**

- I45. If a district has not billed for a particular cost category does that mean that there can be no expenses for that category submitted on the cost report even though equipment and supplies for that cost category were purchased during the cost report period?**

Any equipment, materials and/or supplies purchased for a cost category are not allowable costs if no billing was submitted for the same cost category.

- I46. Can a district make changes to a submitted/closed SHARS Cost Report?**

Yes, provider initiated amendments, corrections and/or adjustments to a closed or submitted cost report may be requested in writing up to 60 days after the original due date of the cost report. Written requests should include the district NPI, TPI, a reason for the request, and must be sent to: ra_shars@hhsc.state.tx.us

Please refer to the SHARS Cost Report Corrections document found on the webpage listed below for additional instructions.

<http://www.hhsc.state.tx.us/rad/acute-care/shars/shars-2012-cost-reports.shtml>.

I47. Why should a district reconcile between the cost report and its billings? How detailed should the reconciliation be? Is it by category or down to the actual participants on the list?

The reconciliation, for cost report purposes, will help the district identify allowable cost categories and thus should be by category. However, districts should maintain detail information with all other SHARS related district records.

I48. Who can I contact if I have questions regarding the cost report?

For questions and assistance with the cost report you may contact the SHARS Rate Analyst(s) at: (512) 730-7400 or ra_shars@hhsc.state.tx.us.

For additional information regarding the SHARS Cost Report refer to: <http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>

J. PSYCHOLOGICAL SERVICES – ASSESSMENT SERVICES

J1. Define and describe assessment services (Psychological Services – Procedure Code 96101) under the SHARS program.

Assessments are activities performed for the purpose of determining eligibility for special education including:

- An initial assessment that leads to the creation of an Individualized Education Program (IEP)
- An assessment for a student that has an existing IEP and is referred for assessment for a different disability, whether or not that assessment leads to a revised IEP
- An assessment that leads to a dismissal from special education

Billable time includes direct testing time with the student, interpreting results when the student is not present, and report writing time when the student is not present. Parent consultation (student present) required during the assessment due to a student's inability to communicate or perform certain required testing activities is also billable as direct testing time. Assessments are billable under procedure code 96101.

J2. Can assessments performed by an educational diagnostician be billed under the SHARS program?

No, assessments billed under the SHARS program cannot be performed by an educational diagnostician. Assessments must be performed by a Licensed Specialist in School Psychology (LSSP), a licensed psychologist or a psychiatrist.

NOTE: Effective 9/1/06 educational diagnosticians were eliminated as approved SHARS providers. HHSC attempted to present an argument to CMS to reinstate educational diagnosticians through SPA 06-028. CMS denied SPA 06-028 in November 2007.

J3. Are initial assessments that don't lead to the creation of an IEP billable?

An initial (psychological) 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. However, if an initial assessment does not lead to the creation of an IEP, that assessment is not billable under the SHARS program.

J4. Are testing, interpretation, and report writing billable under assessments?

Yes, testing, interpretation, and report writing are billable under assessments as long as the initial (psychological) assessment resulted in the creation of an IEP. Procedure code 96101 is the only code that is billable for times when the client is not present (e.g., interpretation time and report writing time). See also response to J2.

J5. May writing the assessment report (96101) be billed separately from the assessment?

Yes. A (psychological) assessment involves direct testing, interpretation, and report writing. Writing the report may occur on a different day than the direct testing. Each activity should be billed on the day it occurred. Documentation must include date, start time, stop time, and a notation as to which activity (i.e., direct testing, interpretation, or report writing) was done.

J6. Does the report writing time include writing the IEP?

No, writing the IEP is not a billable component of assessments.

J7. Must testing time, interpretation and report writing be done during school hours?

No, if the service is performed and properly documented the services are billable regardless of when they were done.

J8. Assessment reports are sometimes written during the ARD meeting. Is this time billable?

Yes, the clinician may bill for report writing during the ARD; however, the ARD meeting itself is not a billable service. See also response to J7.

J9. May assessments for students with visual impairments be billed?

No, visual impairment assessments and visual screenings are not billable SHARS services.

J10. Are autism evaluations a covered SHARS benefit?

Autism evaluations are not reimbursable through the SHARS program. Autism screening is covered by Medicaid benefits when billed by Texas Health Steps providers.

For further information please visit their website at <http://www.txhealthsteps.com/cms/>.

J11. Are any pre-ARD/ARD meetings billable?

Assessment write-ups (i.e., analyzing the data or writing the report) during the ARD meeting is billable. Pre-ARD meetings are not billable because there is no SHARS service being provided to the student.

J12. What are the guidelines for billing reevaluations?

Referrals are generally good for 3 years. This is based on the 3 year reevaluation time required by school districts under IDEA. According to IDEA, the re-evaluation can occur more frequently than the 3-year evaluation timeline, see below:

A reevaluation conducted under 34 CFR 300.303(a):

- May occur not more than once a year, unless the parent and the public agency agree otherwise; and
- Must occur at least once every 3 years, unless the parent and the public agency agree that a reevaluation is unnecessary.

K. RELATED SERVICE EVALUATIONS

K1. Under SHARS, how do related service evaluations differ from assessments?

Evaluations are those activities performed by qualified therapists to determine eligibility for related services (Audiology, Speech-Language Pathology, Occupational Therapy, and Physical Therapy). Billable time includes direct evaluation time. Indirect time for interpretation and report writing are not billable for evaluations.

For information regarding assessments, see response to J1.

When the Admission, Review, Dismissal (ARD) committee determines that a Medicaid student is eligible for special education, therapist evaluations are billable under the appropriate evaluation code even if a therapist's evaluation does not lead to that particular service being included in the IEP

L. PSYCHOLOGICAL SERVICES—TREATMENT SERVICES

L1. How is the determination made as to whether to bill psychological services versus counseling?

This is determined by who provides the services.

Counseling provided by a licensed professional counselor (LPC); licensed clinical social worker (LCSW, formerly LMSW-ACP); or licensed marriage and family therapist (LMFT) should be billed under the procedure codes for counseling.

Behavioral health services and behavioral testing services (any test not used to determine special education eligibility) provided by a licensed specialist in school psychology (LSSP); licensed psychologist; or licensed psychiatrist should be billed under the procedure codes for psychological services-treatment.

L2. Are emergency services included in the IEP under counseling and psychological services reimbursable under SHARS?

School districts may receive reimbursement for emergency counseling and psychological services as long as the IEP includes a behavior improvement plan (BIP) that documents the need for the emergency services and the services are provided by a qualified provider.

L3. How are the services listed in the behavior improvement plan (BIP) billed?

The BIP is part of the IEP. Services listed in the BIP may be billed as counseling or behavioral health services when provided by a qualified provider. See response to Question L1.

L4. What can be provided under Assessment services (96101) for special education determination? What can be provided under Evaluation services for counseling or psychological services?

For assessment services, see response to J1. For evaluations, see response to K1.

Evaluation services for counseling or psychological services are billable as counseling services when delivered by LPCs, LCSWs, LMFTs or psychological services when delivered by LSSPs, licensed psychologists or licensed psychiatrists. Evaluation services for counseling or psychological services are those testing and

evaluation services required to develop or modify a BIP or other plan of care for these services.

- L5. I used to bill for counseling assessments under the “old” Psychological Service code, and was not able to bill SHARS for report writing. Can I bill SHARS for my same services and now bill for report writing under Psychological Services-Assessment Services code?**

Counseling services evaluation is billed as counseling services (procedure code 96152-UB). Psychological services evaluation is billed as psychological services - treatment (procedure code 96152-AH). So, if the purpose of the testing is to establish a plan of care for psychological services, that evaluation must be billed as psychological services - treatment. If the purpose of the testing is to determine eligibility in the special education program, that testing must be billed as evaluation/assessment services (procedure code 96101).

See also the TEA **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>).

M. COUNSELING SERVICES

- M1. Are counseling services provided by a TEA or SBEC-certified counselors billable under SHARS?**

No. Effective September 1, 2006, TEA- or SBEC-certified counselors are not listed as an approved licensed provider in the Texas Medicaid State Plan for SHARS and their services are not billable. Only counseling provided by a licensed professional counselor (LPC); licensed clinical social worker (LCSW, formerly LMSW-ACP); or a licensed marriage and family therapist (LMFT) should be billed under the procedure codes for counseling.

Counseling or testing services provided by a licensed specialist in school psychology (LSSP); licensed psychologist; or licensed psychiatrist should be billed under the procedure codes for psychological services.

- M2. May temporary licensed professional counselors (LPCs) bill for SHARS?**

Yes, counseling services rendered by an LPC or other qualified behavioral health professionals approved in the Texas Medicaid State Plan for SHARS, who have been issued a temporary license may be billed as long as the services were rendered in accordance with their Texas licensure requirements.

- M3. May an LPC intern or LSSP Intern who is supervised by his/her school district supervisor bill for SHARS under the psychological procedure codes (96152-AH or 96153-AH) codes?**

No, according to the Billing Guidelines, the LPC Intern or LSSP Intern may not bill SHARS under the psychological procedure codes because they are not listed as an approved licensed provider in the Texas Medicaid State Plan for SHARS.

NOTE: All interns other than SLP interns cannot bill for their services.

M4. If a district employs a school counselor (NOT a licensed LPC or LSSP) to provide special education counseling services, should they claim those counseling IEPs in their IEP Ratio Count?

Yes, the IEP Ratio is the (total number of Medicaid students with IEPs requiring direct medical services) / (total number of students with IEPs requiring direct medical services). As long as the student has a valid IEP that documents the need for direct medical services, they are to be included in the IEP Ratio count.

N. AUDIOLOGY AND HEARING SERVICES

N1. If a student has Audiological Management as a service listed in their ARD documentation & listed in their IEP Objective, is Audiological Management (includes such services as fitting students with hearing aids, hearing aid molds, checking/adjusting/repairing hearing aids, checking/setting up FM system, etc.) a billable audiology service?

Yes, Audiological Management is a billable service under SHARS audiology services.

O. NURSING SERVICES

O1. Who can provide the nursing services listed in the IEP?

Nursing services can be provided by a registered nurse (RN or APN), a licensed vocational nurse (LVN), or a licensed practical nurse (LPN). Services delegated by an RN or APN and provided by individuals who have been trained are also billable. Examples of individuals to whom an RN or APN might delegate nursing services include special education teachers and school health aides.

O2. What are the various services covered under nursing services? How explicitly do nursing services need to be stated in the IEP?

Effective 9-1-06, school health services are now referred to as nursing services. Nursing services are skilled nursing tasks as defined by the Board of Nursing (BON). A district can receive Medicaid reimbursement for any nursing service that is determined by the ARD/IEP committee to be needed in order for a Medicaid-eligible student to fully participate in school. Due to the wide variation in individual needs, it is impossible to develop an all-inclusive list of nursing services. Examples of reimbursable nursing services include, but are not limited to: inhalation therapy, ventilator monitoring, non-routine medication administration, tracheostomy care, gastrostomy care, ileostomy care, catheterization, tube feeding, suctioning, client training, and assessment of a student's nursing and personal care service's needs. The ARD minutes should include recommendations derived from the RN/APN or physician's evaluation of the student's nursing service's needs. Nursing services need to be stated with the same level of detail as is provided for the other related services. But, due to the type of services, it may be appropriate to add language

such as “as needed”. Remember that the actual format of the IEP is a local policy decision. In order to receive reimbursement, the specific nursing services need to be included in the IEP; but, there is no prescribed wording.

O3. How should the administration of medication be billed?

The way administration of a medication should be billed depends upon whether the medication is considered “routine oral medication” or regular nursing service. That determination should be made by a RN/APN. If the medication is not a routine oral medication, the time spent administering that medication should be accumulated with all the other nursing services for the calendar day and then converted to 15-minute units and billed accordingly. If the medication is a routine oral medication, please maintain the required service logs billable under the appropriate procedure code (medication administration). See also the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>).

O4. When a RN is provided by the district for a student who needs one-on-one services, can the district bill for the entire day?

All nursing services provided in accordance with the IEP can be billed under the SHARS program, whether delivered by RN/APN, LVN, or delegation. If nursing services are needed for the entire day, then an entire day’s worth of services may be billed. Time spent away from the student (e.g., breaks or lunch) must be deducted from that RN’s billable time. If those breaks and lunch are serviced by another RN, then the second RN documents that billable time. According to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>), nursing services that exceed recommended limits will be denied. Providers can appeal denials by submitting required documentation. Required documentation includes, but is not limited to, showing medical necessity, physician referral, IEP documentation, service log, and actual time spent delivering the service.

O5. If a student is unable to feed his/her self and the IEP designates that the student must be hand fed, not tube fed, may this service be billed?

A RN/APN must determine whether this service is a skilled nursing service or a personal care service (not a skilled nursing task) before the service can be billed with the appropriate procedure code.

PCS must be billed as PCS and nursing services billed as nursing tasks. If there is uncertainty whether a task is a personal care service or a nursing service, the SHARS provider should check with their RN or APN who can make that determination.

O6. May a student receive private duty nursing in school?

Yes, private duty nursing is a Medicaid service under the Medicaid Children’s Services CCP program and is primarily available outside the school setting. Private duty nursing services require prior authorization from TMHP and can be delivered in the student’s residence, the student’s school, or the daycare facility. If the private duty nursing services meet all of the student’s nursing services needs documented

in the IEP, then the district should note in the student's IEP that the student's nursing services needs are being met through private duty nursing services. In this situation, the school district would not bill SHARS for any reimbursement for nursing services.

Arrangements can be made with the private duty nursing provider such that the school district performs some nursing services required by the IEP and bills SHARS for reimbursement for those specific nursing services, while the private duty nursing provider delivers all other nursing services.

If there are conflicts between the school's nursing services or the school's personal care services and the private duty nursing services, schools should contact the HHSC Senior Policy Analyst for SHARS, who will in turn request that Case Management for Children and Pregnant Women (CPW) services be used to resolve differences between the school district, the outside provider, and the parent(s)/guardian(s).

O7. Does an LVN need to be supervised by an RN?

The Texas State Medicaid Plan has no supervisory requirements for Nursing Services to be payable through SHARS. However, the Texas Board of Nursing (BON) does have rules regarding supervision requirements that providers must follow. For more information on supervision requirements mandated by the BON please visit <https://www.bon.texas.gov/>.

P. OCCUPATIONAL THERAPY

P1. Can an OT bill for assistive technology training or assistive technology evaluations?

Yes. Districts can bill SHARS for OT evaluation, therapy, training and fitting associated with such devices. The licensed OT can perform the evaluation. The licensed OT or the OT assistant can provide the treatment services. There are two procedure codes for SHARS OT services, one is the procedure code for the evaluation and one set of procedure codes is for the treatment services. There are more OT procedure codes available in the non-school setting. All those OT services are billable for SHARS under the appropriate procedure codes. See also the current TMPPM section on SHARS.

P2. May school districts bill for a licensed provider providing direct service through demonstration of therapeutic activity to teach a non-licensed provider how to assist the student in the classroom?

Yes, it is a billable SHARS service for PT and OT, provided it is included in the IEP and the student is an active participant

- P3. If the frequency/duration does not change from year to year, only minimal change in the IEP goals/objectives, would a “new” prescription be required? Generally, goals/objectives change from school year to school year and we know the prescription is valid for 3 years unless the IEP changes. What specifically constitutes “a change” in the IEP with regards to PT/OT?**

The “change in the IEP” means that there is a change in the plan of care for these services. This in turn, would mean that an evaluation or reevaluation has been done for the student. If an evaluation or reevaluation results in a change in the plan of care for services, that results in a change to the goals and objectives for OT services and the frequency and duration of service remain the same, a new physician's script is not required. However, if the frequency and/or duration of OT service changes, then a new physician's script is required. If there are no changes to the prescription, 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.

- P4. Can a Nurse practitioner bill for OT or PT services?**

No, both OT and PT providers must meet certain certification/licensure requirements in order for the services they provide to be payable through the SHARS program. OT services must be provided by a professional who is licensed by the Texas Board of Occupational Therapy Examiners or a certified occupational therapy assistant acting under the supervision of a qualified occupational therapist. PT services 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.

Q. PHYSICAL THERAPY

- Q1. When a student is in a wheelchair and the physical therapist is making adjustments on the wheelchair and instructing the student on the use of the equipment, is this billable?**

Therapists may bill for time spent in “hands-on” activities with a student. This includes time spent in assisting the student with learning to use adaptive equipment or assistive technology and training staff. Time spent consulting or training staff and developing or modifying the adaptive equipment is NOT billable when the student is not part of the activity.

- Q2. May school districts bill for a licensed provider providing direct service through demonstration of therapeutic activity to teach a non-licensed provider how to assist the student in the classroom?**

Yes, it is a billable SHARS service for PT and OT, provided it is included in the IEP and the student is an active participant

- Q3. If the frequency/duration does not change from year to year and there is only a minimal change in the IEP goals/objectives, would a “new” prescription be required? Generally, goals/objectives change from school year to school year and we know the prescription is valid for 3 years unless the IEP changes. What specifically constitutes “a change” in the IEP with regards to PT/OT?**

The “change in the IEP” means that there is a change in the plan of care for these services. This in turn, would mean that an evaluation or reevaluation has been done for the student. If an evaluation or reevaluation results in a change in the plan of care for services, that results in a change to the goals and objectives for PT services and the frequency and duration of service remain the same, a new physician's script is not required. However, if the frequency and/or duration of PT service changes, then a new physician's script is required. If there are no changes to the prescription, 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.

- Q4. Do Physical Therapists have to sign Physical Therapist Assistant progress notes??**

Notes do need to include the name of the supervising Physical Therapist, however, this is a Texas Board of Physical Therapy Examiners requirement and not a Medicaid requirement.

R. SPEECH AND LANGUAGE SERVICES

- R1. Is a MD referral required for speech therapy?**

Effective 9/1/2003, SHARS requirements allow for either a medical practitioner or a licensed practitioner of the healing arts to provide the referral for speech therapy. Licensed speech-language pathologists (SLPs) are considered licensed practitioners of the healing arts. The speech therapy evaluation and recommendation by the SLP may be considered the referral.

- R2. How often must a referral for speech therapy be obtained?**

Referrals are generally good for 3 years. This is based on the 3 year reevaluation time required by school districts under IDEA. According to this requirement, the re-evaluation can occur more frequently than the 3-year evaluation timeline. For example, if an evaluation or reevaluation results in a change in the Plan of Care for services, then that means a new prescription/referral is required.

- R3. Who can bill for services under speech-language pathology?**

Effective September 1, 2006, under the new SHARS State Plan language, speech therapy services under the SHARS program can be provided by speech/language pathologist (SLP), American Speech-Language-Hearing Association (ASHA) certified SLP with Texas license, ASHA-equivalent SLP, a TEA certified SLP, a SLP

assistant licensed by the state or a grandfathered SLP when the assistant is acting under the supervision or direction of a qualified SLP.

For more information, refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current TMPPM.

R4. May individuals without a master’s degree who were “grandfathered” to meet state requirements as licensed speech language pathologist receive reimbursement for their services?

Yes, as long as they are supervised by an ASHA or ASHA-equivalent SLP.

For more information, refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current TMPPM.

R5. Can individuals with a master’s degree in speech pathology who were “grandfathered” to meet state requirements as licensed speech language pathologist supervise others?

Yes. A SLP with a grandfathered Texas license and a master’s degree is considered an ASHA-equivalent SLP and can supervise speech therapy providers that are not ASHA or ASHA-equivalent SLPs.

For more information refer to the SHARS section of the current TMPPM.

R6. A district has a TEA certified Speech Therapist on the RMTS PL for part of the year and is replaced with an ASHA-certified SLP, but the PL did not reflect this change, can both salaries be claimed on the Cost Report under the Speech Therapist?

Yes, both salaries can be claimed on the cost report under the one speech therapist position. It is allowable because both providers have the appropriate certification and/or licensure, allowing them to provide the same services.

R7. Can a licensed speech-language pathology assistant bill for SHARS reimbursement?

SLP assistants must be supervised by an ASHA or ASHA-equivalent SLP in order for a school district to bill for services provided by SLP assistants.

R8. Can SLP interns bill for their services?

Yes. SLP interns must be supervised by an ASHA or ASHA-equivalent SLP in order for a school district to bill for services provided by SLP interns.

R9. Can TEA certified SLP bill for SHARS reimbursement?

Yes, TEA certified SLPs supervised by an ASHA or ASHA-equivalent SLP can bill for SHARS reimbursement.

For more information, refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current TMPPM.

S. PHYSICIAN SERVICES

S1. What do districts most commonly bill under physician services?

The most common claim for physician services involves obtaining prescriptions/referrals that Medicaid requires for physical therapy and occupational therapy services.

S2. Does the doctor need to see the student?

Whether or not the physician sees the student while reviewing records for writing a prescription/referral is left up to the professional judgment of the physician. The physician is ultimately responsible for the services he/she prescribes; and therefore, the decision for the level of review must be left up to the physician.

See also response to C2.

S3. Can districts bill for a physician's services if the physician does not charge the district for his/her services?

Yes, it is permissible for school districts to bill for physician services under the SHARS program even if a physician does not charge the school district for his or her services. That physician must still participate in the RMTS for the services to be billed to SHARS. However, if the physician is not included on the RMTS participant list for the school district, that physician's services cannot be billed to Medicaid.

S4. May assessments for students with visual impairments be billed under SHARS physician services?

Visual screenings cannot be billed by a SHARS provider, because it is not a SHARS service. See also response to J9.

T. PERSONAL CARE SERVICES

Personal Care Services (PCS) is a benefit of the Medicaid Children's Services - Comprehensive Care Program (Medicaid Children's Services CCP) for Texas Medicaid clients under the age of 21 years, who are not an inpatient or a resident of a hospital, in a nursing facility or intermediate care facility for the mentally retarded, or in an institution for mental disease. PCS are support services provided to clients who meet the definition of medical necessity and require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related functions because of a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition. PCS are provided by someone other than the minor client's legal or foster parent/guardian or the client's spouse.

T1. What are personal cares services (PCS)?

The descriptions for the personal care services codes are:

Procedure Code	Service
T-1019-U5	PCS in the school, each 15 minutes, individual
T-1019-U5-UD	PCS in the school, each 15 minutes, group
T-1019-U6	PCS on the bus, each student one-way trip, individual
T-1019-U6-UD	PCS on the bus, each student one-way trip, group

PCS include a range of human assistance provided to persons with disabilities and chronic conditions which enables them to accomplish age-appropriate tasks that they would normally do for themselves if they did not have a disability or chronic condition. 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 and/or behavioral impairment. Assistance may be in the form of "hands-on assistance" (actually performing a personal care task for a person) or "cueing" the person so that the person performs the task by him/herself. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting (including diapering), transferring, and maintaining continence. ADLs may also include assistance with mobility services (i.e., the ability to move between locations in the individual's environment).

IADLs capture more complex life activities and include personal hygiene, light housework, essential household chores, laundry, meal planning and preparation, transportation, grocery shopping, communication by telephone or other media, medication management, managing finances, getting around and participating in the community, and limited exercises to increase range of motion and flexibility. These are not an all-inclusive list of ADLs and IADLs.

Skilled nursing services that may only be performed or delegated by a registered nurse (RN) or advanced practice nurse (APN) are not considered personal care services. Delegated nursing services are services that are delegated to an individual whom the RN or APN has trained to perform the delegated nursing task. These delegated services must be billed under Nursing Services.

Personal care services are supports that may be provided through:

- Total or partial physical assistance
- Prompting or cueing the student to complete the task
- Redirection, monitoring, and observation that are medically necessary and an integral part of completing a personal care service.

Note: Monitoring and observation means watching for outward visible signs that are likely to occur and for which there is an appropriate personal care intervention. This could include such activities as monitoring a child for seizures or potentially dangerous behaviors.

PCS may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may not be able to dress without instruction on how to do so or reminders of what to do and when. In such cases, PCS may include “cueing” or monitoring to ensure that the individual performs the task properly.

PCS may include observation/monitoring and redirection/intervention for:

- behavior that interferes with completion of ADL or IADL, such as withdrawal or unusual and repetitive habits;
- behavior that is socially offensive;
- behavior that will, or has the potential to, cause injury to the student and/or others; and
- behavior that will, or has the potential to, cause damage to property.

When is it personal care service?

Yes

- Personal Care
 - Goal not to teach or habilitate, but complete the activity
 - Level of assistance is greater than typical child of same age
 - Need for assistance is related to disability/condition that affects function

No

- Nursing
 - Treat
 - Assess
 - Educate
 - Medication administration
- Therapy
 - Rehab/rehabilitation
 - Age appropriate activity

DOCUMENTATION IN THE INDIVIDUALIZED EDUCATION PLAN (IEP)

Indication of placement in a self-contained setting [i.e., Life Skills classroom, Preschool Programs for Children with Disabilities (PPCD), etc.] is not sufficient IEP documentation to support Medicaid reimbursement for PCS.

Personal care services can be provided on a continuing basis or on episodic occasions. Personal care services are provided on a one-on-one basis or group setting.

One-on-One

PCS delivered on a one-on-one basis to one student: (1) all day or (2) at various times throughout the day. Examples of sufficient IEP documentation are indicated below. Documentation of medical necessity is required for PCS. That documentation should include, at a minimum, the diagnosis or diagnoses resulting in the need for PCS and any history of chronic conditions supporting the need for PCS. If the child is receiving one-on-one personal care services, the aide providing the one-on-one personal care services cannot be billed as a group service to other children in the school or on the bus.

Example of documentation in the IEP

Sufficient documentation

- Assistance is required for one-on-one PCS for “Johnny”. PCS needs include observation and redirection of self-injurious behavior. PCS is required throughout the school day and during transportation to and from school on the bus. Johnny has bipolar disorder and gets angry, frustrated very easily. He often displays his anger and frustration

Insufficient documentation

- Assistance is required for one-on-one PCS for “Sue”. Sue has cerebral palsy.

One-on-One PCS Periodically throughout the day

The need for a student to receive one-on-one PCS periodically throughout the day must be documented in the IEP with examples provided. The documentation needs to address of the following items or provide the requested documentation:

- (1) Is the service provided on a one-on-one basis or group or both;
- (2) Examples of PCS;
- (3) When/where are the PCS needed; and
- (4) Reason(s) for PCS, such as medical necessity, etc.

Example of documentation in the IEP

Sufficient documentation

- PCS assistance is required for “Timmy” periodically throughout the day on a one-on-one basis. Timmy has mental retardation and needs periodic PCS to assist him in moving from class to class. Without PCS assistance, Timmy would wander off.

Insufficient documentation

- PCS assistance is required for “Jane” periodically throughout the day on a one-on-one basis because she has visual impairment.

Group PCS

Group PCS are defined as when a staff person or a team of staff members work directly with more than one student (for example, in a self-contained classroom). REMINDER: Indication of placement in a self-contained setting [i.e., Life Skills classroom, Preschool Programs for Children with Disabilities (PPCD), etc.] is not sufficient IEP documentation to support Medicaid reimbursement for PCS.

The need for students to receive group PCS must be documented in the IEP with examples provided. The documentation needs to answer the following questions or provide the requested documentation: (1) Examples of PCS; (2) when are/where are the services needed; and (3) the reason(s) for PCS, such as medical necessity, etc.

Example of documentation in the IEP

Sufficient documentation

- Group PCS assistance is required for “Janice” throughout the day. Janice has ADHD. She has difficulty staying on task and is very impulsive. She requires constant cueing, prompting, and redirection.

Insufficient documentation

- Group PCS assistance is required for “Janice” throughout the day because she has ADHD.

Group PCS with intermittent one-on-one PCS

Students receiving group PCS may also require intermittent one-on-one PCS throughout the day.

Example of documentation in the IEP for group PCS with intermittent one-on-one PCS

Sufficient documentation

- “Sue” is in a self-contained classroom and needs group PCS throughout the day. In addition, Sue needs individual assistance with ADLs, including eating, toileting, mobility, and transfers because she is unable to transfer herself to the toilet and during transportation to and from school on the bus. Sue has cerebral palsy and cannot navigate her chair, feed or toilet herself.

Insufficient documentation

- “Bobby” needs group and one-on-one PCS throughout the day. Bobby is wheelchair bound.

DOCUMENTATION OF SERVICES PROVIDED

One-on-One

In order to bill for PCS, all individual PCS must be documented by including in the service log the start time and stop time for each personal care service task/episode throughout the day, with minutes accumulated for the day for all personal care

services delivered in an individual setting and converted to units, with checkboxes for the various types of personal care services delivered. Personal care services delivered on a one-on-one basis for one student for an entire day must have included in the service log the start time and stop time for the entire day. Service log for PCS must include the signature of the individual that provided the PCS. In cases where more than one person provided PCS throughout the day, only one person needs to sign the service log. **If there are times in the day when the student receives services other than personal care services (e.g., speech therapy, nursing services, and non-SHARS services) and are not accompanied by a PCS attendant, those minutes should be subtracted to arrive at the net personal care services minutes for the day. No session notes are required.**

Group

In order to bill for group PCS, PCS may be documented by indicating the various types of personal care services delivered. In addition, group PCS must document the start time and stop time for each day. **If there are times in the day when the student receives services other than personal care services (e.g., speech therapy, nursing services, and non-SHARS services), those minutes should be subtracted to arrive at the net personal care services minutes for the day. No session notes are required.**

Group and One-on-One

Students receiving group PCS may also require intermittent one-on-one PCS throughout the day.

For example: A student may need one-on-one assistance with toileting. Group PCS documentation must show stop time when documentation for one-on-one PCS assistance starts. Group PCS assistance start time will be documented when one-on-one PCS assistance ends.

Due to the additional paperwork required, districts may choose not to seek reimbursement for episodes of one-on-one PCS time and may bill all of the student's PCS under the group PCS code. **If there are times in the day when the student receives services other than personal care services (e.g., speech therapy, nursing services, and non-SHARS services), those minutes should be subtracted to arrive at the net personal care services minutes for the day. No session notes are required.**

T2. If a student needs constant monitoring all day, even during instructional time, is the entire day billable as personal care services?

The IEP should clearly justify the need for constant supervision or monitoring and any other PCS (such as toileting, feeding, etc.) required during the school day. The documentation justifying the medical necessity of PCS needs to answer the following questions or provide the requested documentation:

- (1) Examples of PCS;
- (2) when/where are the personal care services are needed;

- (3) Reason for PCS (such as medical necessity, etc.); and
- (4) Why can't the student perform the age appropriate task?

T3. Can personal care services be billed under nursing services?

No, personal care services are not skilled nursing tasks. PCS must be billed as PCS and nursing services billed as nursing tasks. If there is uncertainty whether a task is a personal care service or a nursing service, the SHARS provider should check with their RN or APN who can make that determination.

See also response to Question O5.

T4. What is required for documenting services for PCS?

PCS documentation:

- 1) Must capture the minutes of the service with start and stop times,
- 2) Must have notation of specific type of PCS required,
- 3) Must identify type of PCS (one-on-one or group),
- 4) If PCS is provided throughout the day, the accumulation of all the PCS minutes for the day must be totaled and converted to units of service, and
- 5) Must include the signature of the individual that provided the PCS. (In group settings, each caregiver does not have to provide documentation for each child. Rather one caregiver can document for 2 or 3 students while another caregiver documents on the other 2 or 3 students. See also information and examples in response to Question T1.

T5. May we bill SHARS for a student that is severe and profound to have a staff person accompany him/her to the job site or vocation training to provide job coaching and provide monitoring to the student while on the job? Is it billable and how must it be listed in the ARD/IEP?

If a staff person, of the school district, accompanies the student to a job site or vocational training (during school hours), PCS can be billed when the need for PCS at the job site or vocational training (during school hours) is documented in the IEP. The IEP documentation justifying the medical necessity of PCS needs to answer the following questions or provide the requested documentation:

- (1) Examples of PCS;
- (2) when/where are the personal care services are needed;
- (3) Reason(s) for PCS (such as medical necessity, etc.); and
- (4) Why can't the student perform the age appropriate task?

In addition, required PCS documentation of the service(s) provided is outlined in the response to Question T4.

See also information and examples in response to Question T1.

- T6. How do you bill for a full-time childhood special education setting (Early Childhood Intervention – ECI) as it relates to PCS? This setting consists of 3-5 students who have many assistants in the classroom to assist them in most everything they do. Most are severe. Would this be a group PCS?**

ECI is a separate Medicaid program and is not billable under SHARS.

- T7. We have a student in PPCD (Preschool Program for Children with Disabilities) who requires PCS but does not require one-on-one PCS. This student is in the classroom from 8 am to 2 pm or 6 hours/360 minutes. The IEP deducts 60 minutes a day for lunch, etc., showing only 300 minutes. Can the hour for lunch, etc. be included in the group PCS claim? The student must still be fed, changed, cared for during this hour.**

No, because those 60 minutes are not in the student's IEP. If it is not in the IEP, the service cannot be a SHARS reimbursable service. However, if the IEP was changed to include the 60 minutes for lunch, the school district would be able to bill for PCS provided during lunch, beginning with the effective date of the change.

- T8. Who is qualified to provide PCS?**

The state plan for EPSDT services outlines the requirements for a qualified provider in §42 CFR 440.167. PCS must be provided by a qualified provider who is 18 years or older and has been trained to provide the personal care services required by the client, e.g., bus monitor/aide on the bus, special education teacher and special education teacher's aide.

- T9. Can a paraprofessional provide PCS when they interpret to 2 hearing impaired students in a classroom for mainstream students?**

Yes, the paraprofessional would meet the definition of a PCS provider.

- T10. If a student has speech therapy in the life skills classroom because the student can become combative and the therapist wants the teacher's aide to be readily available to assist with the student, should the speech therapist's time be backed out of the total time for PCS?**

Yes. When the speech therapist begins therapy in the life skills classroom, the group PCS should be documented with a stop time and the speech therapist's time should be documented with start and stop time for the period of the therapy session. Because the teacher's aide is simply present in the classroom during the speech therapy, no PCS is being performed and cannot be billed. However, if the teacher's aide is actually required to provide PCS during the same time the speech therapist is providing speech therapy (and documented in the IEP justifying the medical necessity of PCS during speech therapy time), then the PCS could be billed as individual PCS and documented with start and stop time.

T11. Can we bill SHARS for special transportation and PCS, including PCS on the bus, if the IEP does not list special transportation, but does indicate transportation aid on the personal care attendant schedule of services?

If the medical necessity for the PCS is documented in the IEP (to include PCS on the bus), the PCS on the specialized transportation vehicle (PCS on the bus) can be billed to SHARS. The specialized transportation (bus ride) cannot be billed to SHARS because there is no medical necessity for the specialized transportation documented in the IEP. In order to bill SHARS for specialized transportation, the IEP would have to list that the child requires a specific adaptation(s) on a bus/vehicle and why the specific adaptation(s) were needed.

T12. For personnel who have multiple duties, PCS Aide and Bus Driver, would the district claim total compensation and benefits to include both positions under “direct medical” expense?

PCS Aide is a direct medical services provider that would be reported in Step 3 of the SHARS cost report. A bus driver is a transportation employee that would be reported in Step 4 of the cost report. In this scenario, you do not report total compensation and benefits under direct medical expenses. Instead, allocate the total cost of the employee between the two positions held. The ratios within the cost report will then reduce the employee’s costs accordingly.

T13. Can a life skills teacher or aide who provides adaptive P.E. (physical education) be billed under PCS?

Yes, if the PCS service provider assists in providing the adaptive need. For example, the PCS attendant assists with PT, OT, or range of motion. This PCS must be documented in the IEP (as outlined in the responses to Questions T1, T2, and T5 - justifying the medical necessity of PCS) and the service must be documented as outlined in the response to Question T4.

T14. Can we bill for low-functioning children under PCS if they receive help with sorting, numbers, coloring, puzzles, calendars, etc.? If these life skills student goals and objectives are tied to these types of activities, which in some cases may seem academic in nature, are they considered a PCS?

In order to bill for low-functioning children under PCS, the school must look at the purpose of the PCS. If the PCS assistance is to help with range of motion, the PCS is billable to SHARS. If the PCS assistance is to meet academic goals, then no, that is not billable to SHARS. Another question to ask is – are the tasks ones that are age-appropriate for the student? If so, why can the student not perform those tasks? If the reason the student cannot perform the age-appropriate task is because of the student’s physical, cognitive or behavioral disability(ies) that cause the student to be unable to perform these tasks, then yes, that is billable to SHARS PCS. In determining if a SHARS PCS service is billable, it is helpful to know what ADLs and IADLs are associated with these tasks.

T15. We have two students that arrive early and are met by their aide at the bus stop. When do we start billing PCS for SHARS?

If the service is documented in the IEP (including justifying the medical necessity of PCS), the school can begin billing PCS when the aides meet the child at the bus stop. The same applies for after school.

T16. If a life skills student has IEP goals/objectives that outline the Special Olympics/bowling and summer camp activities during the summer months and is transported on a special education bus to the bowling alley for this activity because there are no facilities on campus to support the goals/objectives. Can we bill for the service and for transportation to the off campus sites?

Yes, if the specialized transportation needs are included in the IEP. The IEP must document the medical necessity for specialized transportation, as well as, document the medical necessity for the personal care service and why and how the activities meet the IEP goals/objectives for the life skills student. The IEP must also document what services/activities are ADL, PCS, etc.

T17. If a nurse changes the diaper for a child receiving personal care services during a life skills class, is this billed under nursing services?

In order to bill SHARS for nursing services, it must be documented in the IEP. Billing the diaper change as a nursing service would depend on whether the diaper changing required the special skills of a nurse, e.g. a child with Spina Bifida requiring the application of a salve. In this case of a child with Spina Bifida the diaper change could be billed under nursing services. If the nurse only changed the diaper because the child felt comfortable with the school health professional in this case the diaper change could not be billed under nursing services.

T18. How can the determination be made whether the service should be billed under personal care service or billed under nursing services?

Personal care services are not skilled nursing tasks. PCS must be billed as PCS and nursing services (skilled nursing tasks) must be billed as nursing tasks. If there is uncertainty whether a task is a personal care service or a nursing service, the SHARS provider should check with their RN or APN who can make that determination.

See also responses to Questions O5 and T3.

T19. Is music therapy an allowable SHARS service under PCS?

Generally therapies are not considered PCS. If the district determines that music therapy does in fact fall under PCS, you will need to maintain proper documentation to support the services, including the medical necessity and all other PCS documentation requirements as they may be requested in an audit.

T20. For the Community-based instruction/Vocational training we feel that some activities fall under housekeeping or money management chores, but some activities do not, i.e. teaching a student how to react in their environment as they transition from one class to another or from classroom to lunchroom, from school to work program, etc. Can guidance be provided for Personal Care services definitions and explanations that include Community-based instruction/Vocational training?

In order to bill for PCS services for activities that occur in the Community-based instruction/Vocational training, the activities must meet the criteria of support services provided to clients who meet the definition of medical necessity and require assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health related functions because of a physical, cognitive, or behavioral limitation related to a client's disability or chronic health condition.

See also response and examples listed the response to Question T1.

T21. If the Visual Impairment Specialist(s) is working with a student to assist them in adapting in the classroom using various methods and devices in order to complete assignments, would this type of service be considered a "Personal Care" service by Medicaid definitions & therefore be billable, or at the least "not deducted" from the rest of a student's personal care day?

The Vision Impairment provider can review the visually-impaired student's classroom documents and/or the PCS provider's notation of specific type of PCS provided to be sure that she agrees that the VI specialist is providing PCS in that she is assisting the student with the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) because the student is not able to perform the age appropriate tasks due to his/her disabilities. Services provided by Orientation & Mobility Specialists often meet the definition of PCS for visually-impaired students.

See also response and examples listed in response to Question T1.

T22. We have special education students whose IEPs prescribe redirection services. The teacher and/or teacher's assistant go to the classrooms and/or bring them to the behavior room to talk to them in order to redirect their inappropriate behavior. Different methods are used to help the student deescalate their behavior. Is this an allowable cost under PCS?

In this instance, the services are not billable because they are not medically necessary. Personal care services include a wide range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish age-appropriate tasks that they would normally do for themselves if they did not have a disability or chronic condition. Services must be documented in the student's IEP and that documentation supporting the medical necessity for those services is required. Oftentimes, PCS assistance is prescribed in the IEPs to meet academic goals.

U. SPECIALIZED TRANSPORTATION SERVICES

U1. When can specialized transportation be billed for SHARS?

Specialized transportation service may be Medicaid reimbursable if:

- it is being provided to and from a Medicaid covered (SHARS) service(s) for the day the claim is made;
- the Medicaid covered service(s) is included in the student's IEP;
- the specialized transportation needs are included in the IEP (must include the type of adaptation that is required on the vehicle and why the student needs/requires that adaptation), and
- the child requires transportation in a school bus adapted to serve the needs of a student with a disability.

On a day when the student receives a related Medicaid-covered SHARS service, specialized transportation services may be provided and can include coverage of transportation in the following instances from:

- The student's residence to school
- The school to the student's residence
- The student's residence to a provider's office that is contracted with the district
- A provider's office that is contracted with the district to the student's residence
- School to a provider's office that is contracted with the district
- A provider's office that is contracted with the district to the student's school
- School to another campus to receive a billable SHARS service
- The campus where the student received the SHARS service back to the student's school.

Specialized transportation services from a child's residence to school and return will not be Medicaid reimbursable if, on the day the child is transported, the child does not receive a Medicaid-covered SHARS service other than transportation to the school location.

Documentation of each specialized transportation service provided must be maintained. This documentation may take the form of a trip log. This service must not be billed by default.

See also the response to Question U3. For more information refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) or the SHARS section of the current TMPPM.

U2. Can districts bill for one-way transports?

Yes, specialized transportation must be billed on a one-way-trip basis. (Effective 9/1/2004 specialized transportation is no longer reimbursable on a round-trip basis.)

U3. When can a school district receive reimbursement for specialized transportation? Specifically, a bus is bought with state funds to transport special education students, federal funds are used to add a lift, and the driver is paid out of federal funds? Can these districts still bill for specialized transportation?

The school district may bill for specialized transportation for eligible students whose IEP includes transportation on a specially adapted vehicle and who receive a related SHARS service on the same day. The IEP must include the type of adaptation that is required on the vehicle and why the student needs/requires that adaptation. A specially adapted vehicle is one that has been physically modified (e.g. addition of a wheelchair lift, addition of harnesses or protective restraint devices, addition of child protective seating, or addition of air conditioning).

See also the response to U1. For more information refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) or the SHARS section of the current TMPPM.

U4. Is air conditioning considered adaptive equipment?

Yes, if this is included in the IEP as a need for an individual student. However, if all buses in the school district are air-conditioned, then this is not considered a special adaptation.

U5. All of the buses are fitted with seatbelts that were ordered at factory or have been added to the vehicles after purchase. Since the seatbelts are not standard equipment, and were a special order item, is this considered an adaptive equipment?

No. If the intent of the district is to order buses, from now on, with seatbelts, this is not a special adaptation. If the intent is to identify special education students that require seatbelts and use these buses only for those kids, this is also not a special adaptation.

U6. Please explain the major change that no longer makes riding in an “adapted” vehicle sufficient?

In order to bill for specialized transportation, the child must be transported in a specially adapted district-owned or district-contracted vehicle. Specially adapted means a vehicle that has physical adaptations not normally found on a regular school bus. For example, the vehicle might have a wheelchair lift, harnesses, child-protective seating, or is air conditioned. The presence of a bus monitor does not meet the criteria of a special adaptation.

U7. What if there is a monitor on the bus?

The presence of a bus monitor will no longer be considered a special adaptation. More than likely, the bus monitor services could be billable as “Personal Care Services on the Bus” assuming the appropriate documentation is maintained and the personal care service is in the student’s IEP.

U8. What are the minimum requirements for transportation logs?

At a minimum, the transportation log should include:

- The SHARS provider name (i.e., school district name)
- First Name and Last Name of each student for each trip, along with each student's ID
- One log per vehicle, indicating the route name/number [with documentation maintained somewhere that describes each route/trip as to the start and stop locations]
- Method for identifying the number of one-way trips per day (e.g., AM and PM trips) [with documentation maintained somewhere that describes the times for each trip] -- Remember that the number of one-way specialized transportation trips must be counted for calculating the one-way trip ratio for allocating specialized transportation costs to the Medicaid program.
- Method for personal care services (PCS) provider, transportation aide, bus monitor, or assistant to verify own attendance for each trip and include a place for this person to sign and date the form.
- Method for driver to verify own attendance for each trip and include a place for this person to sign and date the form.
- Method for nurse to verify own attendance for each trip and include a place for this person to sign and date the form.
- The log can be maintained per day and for several days, with applicable dates noted on the log.
- Mileage needs to be maintained somewhere; but, not on the log.

For more information, refer to the **Billing Guidelines** (<http://tea.texas.gov/SHARSbilling.pdf>) and the SHARS section of the current TMPPM.

U9. What signatures or initialing are required to be maintained for documenting the specialized transportation service provided?

The minimum requirements for transportation logs are outlined in the response to Question U8. The transportation log can be every day, weekly, monthly --- just not annually. For daily transportation logs, the bus driver must sign and date the log.

Any nurse, PCS attendant, etc. that provided a service during the bus ride or transportation service can verify his/her own attendance for each trip by initialing the transportation log on the day of the service. The finalized log (log can be every day, weekly, monthly --- just not annually) needs to be signed by the bus driver and the

people that initialed their attendance on the bus that provided a service (PCS person, nurse, etc.).

- U10. The district has a student who attends school only 2 hours per day and is on homebound for the remainder of the student's instruction time. The student's father is paid to transport the student to and from school and to and from physical therapy in another town. The medical need for specialized transportation services are documented in the student's IEP and the vehicle the student is transported in (owned by the parent) is specially adapted. Can the school bill for the specialized transportation services for this student?**

Yes, if the student has an accompanying SHARS service on the day the specialized transportation is provided then the district can bill SHARS for the specialized transportation service for the student:

- when the student is transported in a vehicle (owned by the parent) and
- the vehicle the student is transported in is specially adapted.

- U11. We reported the wrong cost of a vehicle in Step 4E our cost report this year because it was not reported correctly the previous year, how do I fix this?**

You need to first remove the asset from service in the current cost report. When the previous year's cost report is in the Settlement Process, you will need to request an informal review to remove the asset and re-enter it with the correct historical values. Only assets costing \$5,000 and over should be depreciated, anything less should be expensed accordingly.

V. SETTLEMENT PROCESS

- V1. How can we obtain cost report details?**

Cost reports can be viewed and printed from STAIRS.

- V2. When is the Settlement period and how will we know?**

HHSC sends out a SHARS Cost Report Settlement notice on or before August 31. Notices are distributed via Fairbanks email to the district's superintendent, the primary SHARS financial contact and all secondary SHARS financial contacts.

- V3. Our cost report is incorrect and we would like to dispute the Settlement, what do we need to do?**

First, the district must complete Step 8 of the SHARS Cost Report in STAIRS by submitting a "Disagree" response. Next, the district must submit an informal review request. An ISD or their legal representative who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments. The request for an informal review of the adjustments must be sent via certified mail and should include the settlement notice, a concise statement of the specific actions or determinations the district disputes, the ISD's

recommended resolution, and any supporting documentation deemed relevant to the dispute. The request for an informal review must be received by HHSC no later than 30 days after the Settlement Notice has been issued. Failure to follow these instructions will result in the denial of the request. Informal review requests can be sent to:

Certified Mail:
HHSC Rate Analysis
Mail Code: H-400
P. O. Box 149030
Austin, TX 78714

Overnight/Courier Delivery:
HHSC Rate Analysis
Mail Code H-400
4900 North Lamar
Austin, TX 78751

V4. How can we verify the interim payments from TMHP if we do not have any records of receiving interim payments?

School districts receive a weekly Remittance & Status (R&S) report from Texas Medicaid and Healthcare Partnership (TMHP) that provides information on pending, paid, denied, and adjusted claims. The R&S report reflects claim payments processed during the period stated on the report regardless of the SHARS dates of service. It is the district's responsibility to retain copies of all R&S reports for a minimum of seven years and to reconcile their records to the R&S report to determine payments/denials received.

If the district is not receiving these R & S Status reports, please contact the TMHP Contact Center at 1-800-925-9126 and verify the address and location on where these R & S Status reports are being sent.

V5. Our interim payments on the Cost Settlement does not agree with the R&S Statement for the same period, what do we do?

Verify that all paid claims for services delivered during the reporting period have been included in the district's reconciliation total. The R&S report reflects claim payments processed during the period stated on the R & S report. Oftentimes claims are paid in the federal fiscal year that follows the federal fiscal year in which the services were delivered. If the district feels its records are incomplete, please call the TMHP Contact Center at 1-800-925-9126 to request archived copies of past R&S reports.

V6. My settlement reflects a recoupment, how do we repay this amount?

If a provider's interim payments exceed the actual certified Medicaid-allowable costs, 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 overpayment within a year;

- Recoup an agreed-upon dollar amount from future claims payments to ensure recovery of the overpayment within a year.

If you are interested in establishing a special payment arrangement, please contact HHSC for more information. Each request will be evaluated on a case by case basis to determine if a special payment arrangement will be granted.