SHARS Self-Monitoring Tool

Texas Education Agency

Review Period Dates: _____ to _____

LEA Name: _____ Campus Name: _____

Reviewer Name: _____ Date of Review: _____

Section I. General Provider Responsibilities

Review the current Texas Medicaid Provider Procedures Manual (TMPPM) for more detail on sections listed below.

Proof of Implementation

- ❖ Child abuse or neglect reporting (1.7.1.2 through 1.7.1.4) ☐ Yes ☐ No
  - Internal policies describing compliance with state and federal law.
- ❖ Child abuse or neglect training (1.7.1.5) ☐ Yes ☐ No
  - Training on policies regarding reporting child abuse.
- ❖ Provider Information Updates (1.7.2) ☐ Yes ☐ No
  - Changes in provider information must be reported within 90 days of occurrence.
- ❖ Record retention and access (1.7.3) ☐ Yes ☐ No
  - Original documents supporting billing must be maintained to submitted to appropriate state and federal agencies upon request.
- ❖ Provider certifies signed claims (1.7.10) ☐ Yes ☐ No
  - Services are billed only by the local education agency (LEA) who provided the service.
  - Records document services and their **medical necessity**.
  - Services provided without regard to race, color, sex, national origin, age, or handicap.
- ❖ Delegation of signature authority (1.7.10.1) ☐ Yes ☐ No
  - When delegating signature authority, a provider remains responsible for the accuracy of the claim.
- ❖ General medical record documentation (not all-inclusive) (1.7.12) ☐ Yes ☐ No
  - Entries are legible, dated (month, day, and year), and signed by the performing provider.
  - Billing codes are supported by documentation.
- ❖ Reporting fraud, waste, and abuse (1.11.1) ☐ Yes ☐ No
  - Providers are encouraged to voluntarily investigate and report fraud, waste, abuse, or inappropriate payments. Providers are required to report these to HHSC-OIG when identified. HHSC-OIG will work collaboratively with self-reporting providers.

Comments:

Section II. Demographic/ARD Meeting Information Demographics

School District/Campus	Handicapping Condition(s)/Grade *(at the time of review)*
Full Individual Evaluation (FIE) in Effect During Review Period — Date	Medicaid Number/Age *(20 yrs. or younger)*
ARD/IEP in Effect During Review Period — Date(s)	ARD/IEP Date Range(s)

ARD/IEP Committee Members:		SHARS Services in ARD/IEP:	
Parent	Yes ☐ No ☐ N/A ☐	Audiology Services (AT) * *(audiologist, assistant)*	Yes ☐ No ☐
Student	Yes ☐ No ☐ N/A ☐	Counseling * *(LPC, LCSW, LMFT)*	Yes ☐ No ☐
LEA Representative *(admin)*	Yes ☐ No ☐	Psychological Services *(LSSP, psychologist, psychiatrist)*	Yes ☐ No ☐
General Education	Yes ☐ No ☐	Nursing *(RN, LVN, LPN, NP, CNS, ANP, delegated)*	Yes ☐ No ☐
Special Education	Yes ☐ No ☐	Occupational Therapy (OT) * *(OT, COTA)*	Yes ☐ No ☐
Assessment Representative	Yes ☐ No ☐ N/A ☐	Physical Therapy (PT) * *(PT, LPTA)*	Yes ☐ No ☐
AI Teacher:	Yes ☐ No ☐ N/A ☐	Personal Care Services #	Yes ☐ No ☐
VI Teacher:	Yes ☐ No ☐ N/A ☐	Physician # *(physician)*	Yes ☐ No ☐
Other:	Yes ☐ No ☐	Specialized Transportation # *(school bus driver)*	Yes ☐ No ☐
Other:	Yes ☐ No ☐	Speech Therapy (ST) * *(SLP, intern, assistant)*	Yes ☐ No ☐
Other:	Yes ☐ No ☐	Evaluations/ Assessments *(OT, PT, ST, psychological)*	Yes ☐ No ☐

**Requires session notes.* *#Requires service logs.*

Medicaid Number

1. Is the student's name and Medicaid number on each page of the ARD/IEP(s)? Yes ☐ No ☐ _____
2. Is the student's name and Medicaid number on each page of the FIE(s)? Yes ☐ No ☐ _____

Parental Consent to Bill Medicaid

Parent Consent Yes ☐ No ☐	Date Signed:	Medicaid # on Form Yes ☐ No ☐
Annual Written Notice Yes ☐ No ☐ N/A ☐	Date:	Medicaid # on Form Yes ☐ No ☐

1. Do the consent and notice forms meet TEA standards? Yes ☐ No ☐
2. Are the consent and notice forms filled out completely? Yes ☐ No ☐
3. Is the consent date prior to the start of services to be billed? Yes ☐ No ☐
4. Is the annual notice current (within a calendar year)? Yes ☐ No ☐

Section III. Services Requiring Service Logs

Specialized Transportation Service

ARD/IEP:

ARD requires physically adapted vehicle not routinely available. Yes ☐ No ☐
Above vehicle need based on identified handicapping condition in FIE. Yes ☐ No ☐
Frequency/duration indicated. Yes ☐ No ☐
Modality (indicate individual transportation as appropriate). Yes ☐ No ☐

Service Log Review:

Original log created within 7 days. Yes ☐ No ☐
Entries are legible, dated (month, day, and year), and signed by the performing provider. Yes ☐ No ☐
All trip claims are appropriately submitted. Yes ☐ No ☐

TEA does not address specific transportation log requirements (includes bus PCS) pending clarification from HHSC.

Service Provider:

Driver trained and hired (or contracted) with the district/charter. Yes ☐ No ☐

Comments:

Nursing/Medication Administration/Physician Services

ARD/IEP:

Individual health plan (IHP) or Skilled Nursing Supplement approved by RN *(nursing need & activity).* Yes ☐ No ☐
Frequency/duration indicated. Yes ☐ No ☐

Service Log Review:

Original log created within 7 days. Yes ☐ No ☐
Student first and last name, date of birth, and Medicaid number on every page or entry. Yes ☐ No ☐
Date of service (mm/dd/yyyy) Yes ☐ No ☐ Student observation Yes ☐ No ☐
Start and end time Yes ☐ No ☐ Total billable minutes Yes ☐ No ☐
Activity performed Yes ☐ No ☐ SHARS procedure code Yes ☐ No ☐
Entries are legible. Yes ☐ No ☐
At least 1 claim for each service for each student appropriately submitted. Yes ☐ No ☐
Performing provider's printed name, signature, title, and the date of the signature. Yes ☐ No ☐

Student in attendance on dates of service. Yes ☐ No ☐
Service matches ARD/IEP (frequency/activity/modality). Yes ☐ No ☐

Service Provider:

Provider has appropriate certification (*RN, LVN, LPN, NP, CNS, ANP, delegated supervised by RN).* Yes ☐ No ☐

Comments:

Personal Care Services (PCS)

ARD/IEP:

Medical condition established in FIE. Yes ☐ No ☐
Service based on identified handicapping condition in ARD/IEP. Yes ☐ No ☐
Medical need established in ARD. Yes ☐ No ☐
- Not based on age-appropriate skills. Yes ☐ No ☐
- Not based on support for educational task. Yes ☐ No ☐
- Not based on time student is independent. Yes ☐ No ☐
- Not stand-by supervision/monitoring. Yes ☐ No ☐

Frequency and duration clearly indicated. Yes ☐ No ☐
Location (classroom or bus). Yes ☐ No ☐
Goals/activities justified throughout ARD document. Yes ☐ No ☐
Frequency/duration. Yes ☐ No ☐
If time is included outside of school hours, ARD justifies extended school day. Yes ☐ No ☐
(Example: If lunch is included in goals and PCS, this time is included in the total frequency and duration.)

Service Log Review:

Original log created within 7 days. Yes ☐ No ☐
Student first and last name, date of birth, and Medicaid number on every page or entry. Yes ☐ No ☐

Date of service (mm/dd/yyyy) Yes ☐ No ☐		Student observation	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	SHARS procedure code	Yes ☐ No ☐

Entries are legible. Yes ☐ No ☐
Each provider documents their service. Yes ☐ No ☐
All service claims appropriately submitted. Yes ☐ No ☐
Only 1 claim submitted per student per day.
Performing provider's printed name, signature, title, and the date of the signature. Yes ☐ No ☐

TEA does not address specific transportation log requirements (including bus PCS) pending clarification from HHSC.

Student in attendance on dates of service. Yes ☐ No ☐
Service matches ARD/IEP (frequency/activity/modality). Yes ☐ No ☐

Service Provider:

Staff is not a family member of the student. Yes ☐ No ☐

Comments:

Section IV. Services with Session Notes

OT, PT, ST, AT, counseling, psychological service

Name of Service: _____

ARD/IEP:

Medical need established in FIE/eligibility form. Yes ☐ No ☐
Service based on identified handicapping condition in ARD/IEP. Yes ☐ No ☐
Medical need established in ARD. Yes ☐ No ☐
Frequency/duration clearly indicated (direct service). Yes ☐ No ☐
Goals/objectives included in IEP. Yes ☐ No ☐

Session Log Review:

Original log created within 7 days. Yes ☐ No ☐
Student first and last name, date of birth, and Medicaid number on every page or entry. Yes ☐ No ☐

Date of service (mm/dd/yyyy) Yes ☐ No ☐		Student observation	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	SHARS procedure code	Yes ☐ No ☐
Entries are legible.	Yes ☐ No ☐	Individual or group setting	Yes ☐ No ☐
Applicable IEP goal/objective	Yes ☐ No ☐	Student progress (if applicable)	Yes ☐ No ☐

Reason for co-treatment (if applicable) Yes ☐ No ☐
At least 1 claim for each service for each student appropriately submitted. Yes ☐ No ☐
Performing provider's printed name, signature, title, and the date of the signature. Yes ☐ No ☐

Co-treatment reason(s) noted in each log (OT, PT, ST only). Yes ☐ No ☐

Student in attendance on dates of service. Yes ☐ No ☐
Service matches ARD/IEP (frequency and duration/objective/modality). Yes ☐ No ☐

Service Provider:

Current license/certification on file. Yes ☐ No ☐
Active license/certification. Yes ☐ No ☐
Meets service requirements. Yes ☐ No ☐
Supervision required. Yes ☐ No ☐
If so, supervisor:
- has license/certification on file. Yes ☐ No ☐
- has active license/certification. Yes ☐ No ☐
- meets service requirements. Yes ☐ No ☐

Prescription *(OT, PT):* Order for Service
Name/address/phone # of physician, PA, or APRN Yes ☐ No ☐
Title & signature with date (within 3 yrs) Yes ☐ No ☐
NPI registered with Tx Medicaid Yes ☐ No ☐

Referral *(ST and AT):* Request for Evaluation
Name/address/phone # of referrer Yes ☐ No ☐
Title & signature with date (within 3 yrs) Yes ☐ No ☐
NPI registered with Tx Medicaid Yes ☐ No ☐

Comments

Section V. Evaluations

OT, PT, ST, Psychological

ARD/IEP:

Need for assessment is indicated in ARD/IEP. Yes ☐ No ☐ Date: _____

Report reviewed in an ARD. Yes ☐ No ☐ Date: _____

Testing Log Review:

Original log created within 7 days. Yes ☐ No ☐

Student first and last name, date of birth, and Medicaid number on every page or entry. Yes ☐ No ☐

Date of service (mm/dd/yyyy) Yes ☐ No ☐		Student observation	Yes ☐ No ☐
Start and end time	Yes ☐ No ☐	Total billable minutes	Yes ☐ No ☐
Activity performed	Yes ☐ No ☐	SHARS procedure code	Yes ☐ No ☐
Entries are legible.	Yes ☐ No ☐		

At least 1 claim for each service for each student appropriately submitted. Yes ☐ No ☐

Performing provider's printed name, signature, title, and the date of the signature. Yes ☐ No ☐

Multi-team evaluations are noted in each log (if appropriate). Yes ☐ No ☐

Student in attendance on dates of service. Yes ☐ No ☐

Service matches ARD. Yes ☐ No ☐

Service Provider:

Provider has appropriate certification. Yes ☐ No ☐

Comments:

Section VI. Telehealth Services

OT, PT, ST, counseling, psychological services

ARD/IEP:

Service clearly described in ARD, amendment, or other IEP document(s). Yes ☐ No ☐

Service Consent:

Parent consent specific to telehealth service (written or verbally documented). Yes ☐ No ☐
Consent acquired by professional represented the identified service. Yes ☐ No ☐
Group consent acquired from all participating guardians. Yes ☐ No ☐

Service Log Review:

Original log created within 7 days. Yes ☐ No ☐
Log includes all required statements based on the service type. Yes ☐ No ☐
Evidence of audio and visual service included. Yes ☐ No ☐
(If counseling is audio only, reason included in the log.) Yes ☐ No ☐
Entries are legible, dated (month, day, and year), and signed by the performing provider. Yes ☐ No ☐
All trip claims appropriately submitted. Yes ☐ No ☐

Service Provider:

Provider has appropriate certification. Yes ☐ No ☐

Comments: