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

- Internal policies describing compliance with state and federal law. ☐ ☐
- Training on policies regarding reporting child abuse. ☐ ☐
- Changes in provider information must be reported within 90 days of occurrence. ☐ ☐
- Original documents supporting billing must be maintained to submitted to appropriate state and federal agencies upon request. ☐ ☐
- 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. ☐ ☐
- When delegating signature authority, a provider remains responsible for the accuracy of the claim. ☐ ☐
- Entries are legible, dated (month, day, and year), and signed by the performing provider.
- Billing codes are supported by documentation. ☐ ☐
- 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, grandfathered SLP)*	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 indicated Yes ☐ No ☐
Modality (indicate individual transportation as appropriate) Yes ☐ No ☐

Service Log Review:

Entries are legible, dated (month, day, and year), and signed by the performing provider. Yes ☐ No ☐

TEA does not address specific transportation log requirements 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 approved by RN *(nursing need & activity)* Yes ☐ No ☐
Frequency indicated Yes ☐ No ☐

Service Log Review:

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 ☐	Procedure code	Yes ☐ No ☐
Entries are legible.	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 and 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:

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 ☐	Procedure code	Yes ☐	No ☐
Entries are legible.	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:

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 and duration clearly indicated (direct service)	Yes ☐ No ☐
Goals/objectives included in IEP	Yes ☐ No ☐

Session Log Review:

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 ☐	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 ☐
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 ☐SI
Signature with date (within 3 yrs)	Yes ☐ No ☐
NPI	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	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:

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 ☐ Procedure code Yes ☐ No ☐

Entries are legible. 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 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: