# Vocational Rehabilitation Services Manual Section C-700

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## Notes on the Manual

On October 1, 2017, Texas Workforce Commission’s Blind Services Division and Rehabilitation Services Division combined to create a single designated state unit (DSU) to administer the vocational rehabilitation program for Texans with disabilities.

The combined Vocational Rehabilitation Services Manual (VRSM) was initially published on October 1, 2017. The latest update to this manual is reflected in the chapters below.

Please note that VRSM includes links to information that is intended to provide additional decision-making supports to VR staff. Some of this information may not be available to individuals who are accessing the VRSM outside of TWC's firewall. Copies of materials that cannot be accessed directly through links can be made available upon request.

Substantive revisions to the content are noted in the VRSM List of Revisions. Any printed versions may not contain the latest policy changes.

If you have any questions about VRSM content, please contact the TWC Vocational Rehabilitation Division Policy Team at state office by sending an email message to [vrsm.support@twc.texas.gov](mailto:vrsm.support@twc.texas.gov).

## Manual Overview

The VR Services Manual:

* helps ensure VR customers receive quality services to assist them in achieving successful competitive integrated employment outcomes as a result of their participation in vocational rehabilitation services.;
* helps to ensure taxpayer funds are spent wisely and each purchase paid for with public funds represents full value to the taxpayer; and
* provides published policies and procedures for maintaining compliance with federal and state laws, statutes, and rules or regulations.

The latest update to this manual is reflected in the chapters below. Any printed versions may not contain the latest policy changes.

# Vocational Rehabilitation Services Manual C-700: Medical Services and Equipment

## C-700: Medical Services and Equipment

Medical services, which are also referred to as "physical restoration," are available to eligible Vocational Rehabilitation (VR) customers through the Texas Workforce Commission's (TWC) Vocational Rehabilitation Services (VR) when these services are expected to decrease, help manage, or stabilize physical barriers so that eligible customers can secure, keep, advance in, or return to competitive integrated employment. These services include corrective surgery or physical therapeutic treatment, dentistry, various types of therapy, and other medically related rehabilitation services that are likely, within a reasonable time frame, to correct or substantially modify a stable or slowly progressing physical or mental impairment that constitutes a substantial impediment to employment.

### C-700-1: Legal Authority

The Code of Federal Regulations (CFR) states:

"(39) Physical and mental restoration services means -

(i) Corrective surgery or therapeutic treatment that is likely, within a reasonable period, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment;

(ii) Diagnosis of and treatment for mental or emotional disorders by qualified personnel in accordance with State licensure laws;

(iii) Dentistry;

(iv) Nursing services;

(v) Necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;

(vi) Drugs and supplies;

(vii) Prosthetic and orthotic devices;

(viii) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids prescribed by personnel who are qualified in accordance with State licensure laws;

(ix) Podiatry;

(x) Physical therapy;

(xi) Occupational therapy;

(xii) Speech or hearing therapy;

(xiii) Mental health services;

(xiv) Treatment of either acute or chronic medical complications and emergencies that are associated with or arise out of the provision of physical and mental restoration services, or that are inherent in the condition under treatment;

(xv) Special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and

(xvi) Other medical or medically related rehabilitation services."

(Authority: 34 CFR 361.5(39) (40); §§12(c) and 103(a)(6) of the Rehabilitation Act of 1973, as amended; 29 USC. 709(c) and 723(a)(6))

## C-701: Professional Medical Services

Federal law requires that medical services (including corrective surgery or treatment) that are sponsored or supported by Vocational Rehabilitation services (VR) must:

* have a direct effect on the customer's functional ability to perform the employment goal or the services must support other needed vocational rehabilitation services; and
* be likely, within a reasonable period, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment.

34 CFR 361.5(39) (i)

VR is the payer of last resort.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in VRSM D-203-2: Best Value Purchasing.

After the customer's primary and/or secondary benefit coverage has been applied and the customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance, or deductible due. VR payment does not exceed the amount allowed by the insurance coverage or the allowable VR rate or VR contract rate, whichever is less.

### C-701-1: Restrictions

When approval for any procedure, service, food, or device is required, the review and approval must be completed and documented in ReHabWorks (RHW) before including the services on the customer's individualized plan for employment (IPE) or IPE amendment.

The following medical services are not authorized:

* ongoing general medical care for health maintenance;
* emerging technology and temporary, experimental, or investigational medical services (terminology codes, also called T-codes);
* maternity care; and
* medical or surgical treatment associated with:
  + active tuberculosis;
  + sexually transmitted diseases;
  + cancer;
  + organ transplantation (except for the treatment of individuals with end-stage renal disease, subject to management review and approval, as set out below); or
  + human immunodeficiency virus infection (HIV) or acquired immunodeficiency syndrome (AIDS).

A corneal transplant, also known as keratoplasty, is a surgical procedure in which a damaged or diseased cornea is replaced by donated corneal tissue. Corneal tissue is not considered an organ; therefore, corneal transplants are not considered organ transplants and are not restricted.

Management exceptions to this list are not allowed.

#### End-Stage Renal Disease

Federal guidelines at 34 CFR 361.5(39) (xv) mandate certain vocational rehabilitation services for customers with end-stage renal disease. These customers' cases must be reviewed by the:

* local medical consultant (LMC);
* VR manager;
* state program specialist for physical disabilities; and
* VR medical director.

### C-701-2: Medical Services Required Review, Consultation, and Approvals Policy

Medical consultants provide support to VR staff throughout the VR process.

For limitations on consultant services and more information about the roles of various consultants, refer to VRSM B-101-7: Consultants.

#### Medical Director

The following require consultation with the medical director:

* Medical services with payments exceeding the Maximum Affordable Payment Schedule (MAPS);
* Medical services or devices with unlisted MAPS codes;
* Payment for co-surgeons;
* Actions contrary to the LMC's advice; and
* Services, procedures, and programs with special requirements.

VR staff must consult with the VR Manager prior to requesting a consultation with the medical director. The medical director will provide a recommendation to the VR counselor. Any decision contrary to the medical director’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### State Ophthalmological Consultants

The state ophthalmological consultant is an ophthalmologist. VR staff must direct ophthalmological and surgical questions to their attention.  When a consultation is required, the state ophthalmological consultant will provide a recommendation to the VR counselor. Any decision contrary to the state ophthalmological consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### State Optometric Consultants

State optometric consultants are optometrists and clinical low-vision specialists. Low-vision, vision therapy, and related optometric questions are directed to their attention.  When a consultation is required, the state optometric consultant will provide a recommendation to the VR counselor. Any decision contrary to the state optometric consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### State Physical Medicine and Rehabilitation Consultant

The state physical medicine and rehabilitation (PM&R) consultant reviews cases and provides guidance on the physical status and prognosis of customers with brain injuries and customers in the ESBI (Employment Supports for Brain Injury) program to help VR counselors determine a customer’s ability to return to work and participate in the VR process.  When a consultation is required, the state PM&R consultant will provide a recommendation to the VR counselor. Any decision contrary to the state PM&R consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### State Neuropsychological Consultant

The state neuropsychological consultant reviews cases and provides guidance on the mental status and prognosis of customers with brain injuries and customers in the ESBI program to help VR counselors determine a customer’s ability to return to work and participate in the VR process.  When a consultation is required, the state neuropsychological consultant will provide a recommendation to the VR counselor. Any decision contrary to the state neuropsychological consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### Regional Dental Consultant

A regional dental consultant (RDC) is required for all dental services.  The regional dental consultant will provide a recommendation to the VR counselor. Any decision contrary to the regional dental consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

#### Local Medical Consultant

The following require review and consultation by an LMC:

* Surgical services, with the exception of eye surgeries, and
* Procedures requiring local and general anesthesia.

Some services, procedures, and programs with special requirements require LMC review and consultations. Refer to VRSM C-703: Policies for Services, Procedures, and Programs with Special Requirements and the particular service to determine the approvals, consultations, and documentation required.  When a consultation is required, the local medical consultant will provide a recommendation to the VR counselor. Any decision contrary to the local medical consultant’s recommendation requires consultation with the VR Manager prior to requesting consultation with the medical director. The medical director will provide a recommendation to the VR counselor. Any decision contrary to the medical director’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

Eye surgeries with complex procedures may need more consultation. VR staff may contact the state office program specialist for blind services at [BVI\_staffing@twc.texas.gov](http://mailto:BVI_staffing@twc.texas.gov/).

For more information, refer to VRSM C-703-36: Eye Surgery and Treatment for Eye Conditions.

#### Medical Services Procedures

When medical services are being considered, the following procedures must be followed:

1. The vocational rehabilitation counselor (VR counselor) documents in a case note how the customer's substantial impediments to employment will be addressed by the proposed medical services to allow the customer to return to, obtain, maintain, or advance in competitive integrated employment.
2. The VR counselor or the designee submits all required documentation for required reviews, consultations, and approvals to the appropriate source for review and approval.
3. All required reviews, consultations, and approvals are documented in RHW.
4. If a consultation was completed by one of the medical consultants, the VR counselor reviews the consultant’s recommendations. If in agreement, the VR counselor proceeds with providing the recommended medical services. If the VR counselor does not agree with the consultant’s recommendations and wants to proceed with a decision contrary to the medical consultant’s recommendation, the VR counselor proceeds with obtaining approval from the Deputy Division Director of Field Services Delivery.
5. After confirming documentation of all required reviews, consultations, and approvals, medical services must be included in the customer's IPE or IPE amendment.
6. The VR counselor provides counseling and guidance to ensure that the customer understands the recommended treatment and the customer's responsibilities throughout the physical restoration process.

Note: If VR staff obtain additional information or records that may influence a recommendation after the case has been sent or reviewed by the medical director or state consultant, reach out to the appropriate email box to provide the additional information.

For additional information about the customer's medical condition, treatment options, and potential employment impact, consult the Medical Disability Guidelines located on the Medical Services Intranet page.

The VR counselor uses the following procedures when authorizing medical services.

1. Review the customer's medical records related to the reported disability.
2. Obtain a written recommendation for planned medical services.
3. Obtain the current procedural terminology codes from the surgeon or physician for the recommended procedures.

#### Steps for Completing VR-sponsored Surgeries

Before developing the IPE, if the recommendations include VR-sponsored surgeries (excluding eye treatments or surgery), VR staff must:

1. obtain the completed a Form VR3110, Surgery and Treatment Recommendations;
2. have the LMC review the Form VR3110;
3. have the LMC complete a Form VR3101, Consultant Review, before creating the IPE for medical services;
4. consult with the VR program specialist for physical restoration for medical services that:
   * are not listed in MAPS;
   * use codes listed as $0; or
   * use codes ending in "99" or the letter "T"; and
5. document the outcome of the LMC in a case note in RHW.

Note:

* When eye surgery or treatment is recommended, refer to VRSM C-703-36: Eye Surgery and Treatment for Eye Conditions for surgery process.
* When dental services require review and approval, the VR counselor completes each of the steps that are listed above and asks the regional dental consultant to complete the Form VR3101, Consultant Review, before services are approved.

If the provider requests authorization for services that exceed the MAPS rates, the VR counselor must consult with the VR medical director.

Justification of a payment rate that exceeds the MAPS rate must show that the:

* customer is an established patient of the medical provider;
* a limited number of medical providers exists in the geographical area where the customer resides;
* surgery or procedure is complicated and requires the special expertise of the medical provider; or
* rate is the best value to VR.

If requesting a state ophthalmological or state optometric consultant review, the VR counselor:

* completes Form VR2351, Request for MAPS Consultation for Visual Services, which states the name of the appropriate consultant, explains the reason for the request, and lists all the codes and dollar amounts associated with the request;
* includes all pertinent background materials (such as eye exams, other medical reports, and provider comments and recommendations) as well as invoices or other documentation submitted by the provider;
* emails information to the VR Medical Services program specialist for physical restoration at [vr.mapsinquiry\_blindservices@twc.texas.gov](mailto:vr.mapsinquiry_blindservices@twc.texas.gov); and
* takes responsibility for:
  + documenting the consultant's response in the customer's case records;
  + ensuring that the service is provided in accordance with the consultant's recommendations if the VR counselor agrees with the recommendations. If the VR counselor would like to proceed with a decision contrary to the consultant’s recommendation, the VR counselor proceeds with obtaining approval from the Deputy Division Director of Field Services Delivery; and
  + processing payment for the completed service in accordance with all programmatic and purchasing requirements.

Local field office staff must coordinate any medical services that are provided in an in-office or facility setting that only requires local anesthesia. These types of medical services may include medical evaluation and treatment in a physician's office, including surgical consultations pre- and post-surgery and other physical restoration procedures provided in an office setting with local anesthesia, therapy services, durable medical equipment, and prosthetic or orthotic services.

Exception: The local field office staff may coordinate a laboratory or radiology diagnostic test at a hospital or facility if the diagnostic test is ordered by a physician in conjunction with a medical evaluation and the laboratory or radiology order does not allow time for MSC coordination of the requested diagnostic test. In that case, the local field office staff obtains guidance from the MSC before issuing the service authorization.

Note: For the purpose of VR service delivery, local anesthesia is considered a local topical anesthetic or a local subconjunctival lidocaine or retrobulbar injection that is used during in-office procedures with no anesthesia staff present and does not require a separate billing from an Anesthesiologist or certified registered nurse anesthetist (CRNA).

### C-701-3: Coordinating with the Medical Services Coordinator

If the VR counselor determines the case should be coordinated by the MSC, the designated medical services coordinator (MSC) coordinates all customer physical restoration services that will be provided in a hospital, ambulatory surgical center, post-acute brain injury facility, or medical school where local/monitored anesthesia care (MAC) or general anesthesia will be used during the surgery or procedure.

#### Role of the Medical Services Coordinator

The MSC must coordinate:

* any hospital inpatient and outpatient medical services when local/MAC or general anesthesia is used;
* ambulatory surgical center services when local/MAC or general anesthesia is used;
* residential and non-residential employment supports for brain injury (ESBI); and
* treatment at medical schools.

The MSC coordinates all durable medical equipment for the first two weeks following discharge for in-region cases and the first 30 days for out-of-region cases. Medications for discharge must be coordinated between the rehabilitation assistant (RA) and VR counselor team and the MSC before the customer's discharge.

For MSC-coordinated services, the VR counselor sends a complete courtesy case of required information to the designated MSC. For out-of-region customer medical services, the VR counselor sends the courtesy case to the designated in-region MSC (Home MSC), who will:

* manage out-of-region cases as per regional policy for coordination of the service; and
* notify the counselor of the case assignment.

When out-of-region services are completed, the Service MSC notifies the Home MSC and the VR counselor that the services have been completed. The Service MSC then transfers the medical services coordination of the case back to the Home MSC for additional services that must be provided in the home region.

When coordinating medical services, the MSC must:

* serve as the VR point of contact with the medical provider to coordinate the services;
* review and verify comparable benefits and release of information forms submitted by the RA and VR counselor team;
* obtain a cost estimate for medical services and notify the counselor;
* issue service authorizations for service and all anticipated ancillary services;
* obtain admission or start dates for services and notify the customer as directed by the VR counselor;
* verify customer admission, discharge, and completion of service;
* notify the VR counselor of case-coordination issues or medical complications requiring authorization of additional services;
* coordinate discharge durable medical equipment needs for the customer; and
* coordinate medications for discharge between the RA and VR counselor team and the MSC before the customer's discharge.

The MSC also must:

* pay medical provider bills and send paid bills to the VR counselor;
* obtain customer treatment records and send records to the VR counselor; and
* document in RHW the MSC case actions related to the coordination of medical services, including:
  + comparable benefit verification information with contact name and date;
  + specific medical service coordinated, including the provider name, admission or start date of service, and number of units or days authorized;
  + for surgery cases, the name of the surgery, surgeon, hospital or facility, and admission and surgery date;
  + verification of discharge date, end date of service, and customer completion of service;
  + a list of ancillary providers required for coordination of the primary medical service;
  + customer medical complications and requests for additional services or an extension of services;
  + the reason for delay in the coordination of medical services;
  + the VR counselor contact information to discuss medical coordination case issues; and
  + the medical provider contacts to coordinate and pay for medical services.

#### Process at Completion of Medical Services

The VR counselor:

* contacts the customer at the time of hospital discharge to ensure that the customer understands postoperative instructions and is aware that he or she must notify the physician and the VR counselor if there are signs and/or symptoms of a potential medical complication;
* provides monitoring and support to the customer during rehabilitative treatment to assess progress and compliance with the treatment regimen;
* obtains verbal or written information about changes in functional limitations or work capacity from the service provider;
* identifies the customer's long-term and ongoing medical needs after VR sponsorship of physical restoration services ends and discusses with the customer the plans for meeting those needs; and
* documents how the impediment to employment has changed because of the physical restoration service by using one of the following:
  + Form VR3106, Work Restriction Checklist
  + A functional capacity evaluation
  + Clinic or progress notes
  + An RHW case note

Exception: Intercurrent illness and dental treatment do not require assessment of residual functional limitations.

### C-701-4: Necessary Unplanned Medical Services

The VR counselor or MSC must not authorize payment for any vocationally necessary medical service that has not been approved by means of a service authorization before the provision of the service. If additional medical services are necessary, the provider must ask the VR counselor or the MSC to request a service authorization before providing the additional services.

Exceptions: Invoices to VR for vocationally necessary medical services that were provided without prior VR approval should be infrequent and must be for immediate services that were required for a customer's safety and welfare.

Refer to VRSM D-204: The Purchasing Process for more information about processing after-the-fact service authorizations.

### C-701-5: Treatment of Medical Complications

#### Legal Authority

The definition of physical and mental restoration services as stated in the CFR is as follows:

"(39) Physical and mental restoration services means—

(xiv) Treatment of either acute or chronic medical complications and emergencies that are associated with or arise out of the provision of physical and mental restoration services, or that are inherent in the condition under treatment."

34 CFR §361.5(39) (xiv)

#### Policy

If the customer does not recover sufficiently from medical complications within a reasonable period, and the VR counselor concludes that the customer is no longer able to participate in VR services, the VR counselor must refer the customer to other comparable benefits for additional services and support.

After reviewing and documenting the circumstances of the case closure with the manager and the MSC, the VR counselor must notify the following individuals in writing if the decision is made to close the customer's case:

* Customer
* Customer's family
* Hospital representative
* Attending physician

If the closure reason is "disability too severe," the VR counselor refers to VRSM B-600: Closure and Post-Employment Services for required closure procedures for all closure reasons.

#### Procedure

The MSC is responsible for confirming that the customer is discharged from the hospital or facility as planned and in accordance with the number of days documented on the service authorization. If the customer is not discharged as planned because of medical complications, the MSC and the VR counselor follow the procedures in the Medical Services Required Practices Handbook located on the medical Services Intranet page.

The MSC is the point of contact with the hospital or facility with respect to the authorization of additional hospital days and medical treatment. The VR counselor assesses the prognosis for recovery within a time frame that will permit the customer to participate in VR services that lead to employment and, when necessary, consults the LMC.

### C-701-6: Comparable Services and Benefits for Restoration Services

#### Legal Authority

Federal law requires state VR programs, when providing VR services, to determine whether comparable services and benefits exist and are available to the individual. Specifically, 34 CFR §361.53, entitled "Comparable services and benefits," states:

"(a) Determination of availability. The vocational rehabilitation services portion of the Unified or Combined State Plan must assure that prior to providing an accommodation or auxiliary aid or service or any vocational rehabilitation services, except those services listed in paragraph (b) of this section, to an eligible individual or to members of the individual's family, the State unit must determine whether comparable services and benefits, as defined in §361.5(c)(8), exist under any other program and whether those services and benefits are available to the individual unless such a determination would interrupt or delay—

(1) The progress of the individual toward achieving the employment outcome identified in the individualized plan for employment;

(2) An immediate job placement; or

(3) The provision of vocational rehabilitation services to any individual who is determined to be at extreme medical risk, based on medical evidence provided by an appropriate qualified medical professional."

#### Policy

When a customer is determined to be eligible for services, all available comparable services and benefits must be used for planned physical restoration before using VR funds.

The VR counselor:

* assesses the availability of comparable services and benefits;
* advises the customer to apply for them; and
* assists the customer with the applications, as needed.

An identified comparable service or benefit is used unless:

* the use of the comparable service or benefit would result in an interruption or delay in the provision of VR services to a customer who has been determined to be at medical risk, based on medical evidence provided by an appropriate qualified medical professional; and
* the treating physician who has an established relationship with the customer does not have privileges to perform the service at the hospital or facility where the comparable benefit is available.

If comparable benefits are verified, VR may pay the customer's portion, to include the deductible, coinsurance, and/or co-pay amount, if the customer's portion does not exceed the maximum amount allowed by:

* MAPS;
* the contracted payment rate; or
* the retail or negotiated lower price (for non-MAPS, noncontract items).

The VR counselor must ensure that consideration is given to the customer's participation in cost of services. Payment of the customer's portion by VR should be considered only when:

* the customer demonstrates financial need; and
* payment of the customer's portion is less than what VR would pay in the absence of a comparable benefit.

If the comparable benefit is:

* major medical insurance, a health maintenance organization, or preferred provider organization, then VR may pay the customer's portion (co-payment, coinsurance, and unmet deductible) not to exceed the MAPS rate, contract rate, or retail price, as applicable;
* Medicare, then VR may pay the customer's portion (co-payment, coinsurance, and any unmet deductible) not to exceed the MAPS rate, contract rate, or retail price, as applicable; or
* Medicaid, then VR pays nothing. VR does not supplement a Medicaid payment for a specific service or procedure. However, if Medicaid does not cover a service that VR has determined is vocationally necessary, VR can cover the cost of the approved service.

#### Explanation of Benefits

When a customer has health insurance, Medicare, or Medicaid, the provider first submits a timely claim to these entities, as applicable, for payment of the provided medical services. An Explanation of Benefits (EOB) is sent to the medical provider to document the payment made per benefit coverage and the patient's payment responsibility (the customer's portion). The medical provider submits to VR a copy of the EOB with the provider's invoice so that the VR payment responsibility can be determined.

If the comparable benefit denies the service, then the VR counselor reviews the EOB to determine the reason for the denial. If the service was denied for insufficient documentation, the VR counselor contacts the medical provider and requests that the provider resubmit the claim with proper documentation. VR is not responsible for payment of services when a medical provider fails to file the claim with the comparable benefit in a timely manner.

### C-701-7: Professional Medical Providers

#### Policy

Medical treatment must be provided, as appropriate, only by a Texas licensed and/or certified:

* physician;
* surgeon;
* anesthesiologist;
* assistant surgeon;
* chiropractor;
* radiologist;
* pathologist;
* physician's assistant;
* nurse practitioner;
* physical therapist;
* occupational therapist;
* speech therapist; and/or
* registered nurse anesthetist.

A physician's assistant (PA) and a nurse practitioner provide medical services under the licensure and supervision of a physician. However, they may evaluate and treat a customer, as well as issue a report, without a physician's co-signature.

For additional information about required qualifications of health care providers, refer to VRSM D-200: Purchasing Goods and Services.

#### Procedure

The medical provider must send documentation along with the invoice for payment that the medical service was provided. Examples of acceptable documentation include:

* medical report or office notes;
* operative report;
* therapy evaluations and progress notes; and
* diagnostic test reports.

If a medical evaluation is purchased, the evaluation report must address the following:

* Medical history
* Reported symptoms
* Review of body systems
* Clinical examination findings
* Diagnoses of medical conditions
* Recommended treatment

### C-701-8: Payment to Medical Providers

The following conditions apply to payment for professional medical services:

* Payment for medical treatment must be the professional's usual fees or the MAPS maximum payment rate for the medical service, whichever is less.
* If the medical professional's usual fee exceeds the MAPS maximum payment rate, the VR counselor verifies that the medical professional providing the service will agree to accept the VR allowance in MAPS as payment in full before coordinating services.
* If the medical provider requests payment that exceeds the MAPS rate for the medical service, the VR counselor must consult with the VR medical director.
* The VR counselor consults with the VR program specialist for physical restoration if the VR counselor is requested to authorize medical services not listed in MAPS.
* Medical providers are not paid maintenance or a per diem.

### C-701-9: Professional Surgical Services Policies

#### Surgeon

The surgeon's fee usually includes postoperative office visits for a specified period. The period should be verified for each individual customer and surgery.

A medical complication that results from the surgery directly or is inherent in the condition under treatment is a part of the physical restoration service.

VR uses a multiple surgical procedure discount when calculating the surgeon's fee per MAPS. Refer to the Medical Services Required Practices Handbook located on the Medical Services Intranet page for the payment method.

#### Co-Surgeons

Two surgeons may not be paid as co-surgeons on the same case at the same time except when the surgery requires the collaboration of two or more surgical specialties.

For approval of co-surgeons, the VR counselor:

* obtains a separate Form VR3110, Surgery and Treatment Recommendations, or Form VR3109, Eye Surgery and Treatment Recommendations, from each surgeon;
* verifies that the identified surgeons have different specialties required by the proposed surgery;
* verifies that the current procedural terminology (CPT) codes identifying the surgical procedures are different for each surgeon; and
* consults with the VR medical director to pay for co-surgeons.

#### Surgical Assistant

A licensed physician, licensed PA, licensed surgical assistant, or registered nurse first assistant may be paid as a surgical assistant. The VR counselor refers to the Medical Services Required Practices Handbook located on the Medical Services Intranet page for the payment method.

#### Anesthesiology Services

A fee for the administration of anesthesia during a surgical procedure is paid to an anesthesiologist or a certified registered nurse anesthetist (CRNA). When a CRNA administers anesthesia under the supervision of an anesthesiologist, the supervising anesthesiologist may be paid for supervising the CRNA. The VR counselor refers to the Medical Services Required Practices Handbook located on the Medical Services Intranet page for the payment method.

A fee for anesthesia may not be paid to a physician or surgeon who administers a local anesthetic agent when performing an office procedure.

### C-701-10: Telehealth for Medical Services

When considering telehealth options for customers, refer to VRSM D-221: Telehealth Options.

## C-702: Clinical Settings Policies

Physical restoration services include a range of medical services provided in a variety of clinical settings such as hospitals, outpatient facilities, and doctors' offices.

VR is the payer of last resort.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in VRSM D-203-1: Best Value Purchasing.

With respect to VR's responsibility for payment, after the customer's primary and/or secondary benefit coverage has been applied and the customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance, or deductible due. VR payment does not exceed the amount allowed by the insurance or the allowable VR rate or VR contract rate, whichever is less.

Refer to VRSM D-220: Health Care Facilities - Required Qualifications for additional information about required qualifications of health care facilities.

### C-702-1: Ambulatory Surgery Center Services

Generally, medical procedures performed in an ambulatory surgery center (ASC) are less complicated than procedures performed in a hospital and do not require an overnight stay. The MAPS codes that are used to pay the surgeon and the ASC are the same except for the code for the facility, which is "FAC" (for example, "69930 FAC"). The VR counselor obtains a copy of the operative report and/or the discharge summary before authorizing payment.

### C-702-2: Hospital or Medical Facility Services

Hospitals or medical facilities must have a written contract with TWC to receive payment for provided services. The TWC Contract Management Unit (CMU) maintains all hospital and medical facility contracts. The hospital or medical facility contract defines the business relationship with VR as well as the rate of payment for services, which may include:

* inpatient hospital services;
* outpatient hospital services;
* residential employment supports for brain injury;
* nonresidential employment supports for brain injury; and
* medical records.

When hospital or medical facility services are necessary, the VR counselor selects a hospital or facility that has a TWC contract, if possible. If a physician selects a hospital or facility for a medical service that does not have a TWC contract, the medical services coordinator must contact the physician's office to determine whether the physician has hospital and facility privileges at a TWC-contracted hospital and if the surgery or procedure can be moved to the TWC-contracted hospital.

### C-702-3: Necessary Medical Services at Non-Contracted Hospital or Medical Facility

If a customer needs a medical service at a hospital or medical facility that does not have a TWC contract, the assigned MSC must contact the CMU to develop a single-customer contract with a negotiated payment rate for the medical service before authorizing the service. A Form VR3423, Exception to Contracted Hospital Purchase must be completed to initiate the approval process.

The VR counselor may refer to VRSM D-210-3: Exceptions to Hospital Contracts for a list of required processes and procedures.

### C-702-4: Selecting the Appropriate Facility

The customer's treating physician can provide guidance on whether a contracted hospital or noncontracted ASC will best meet the customer's needs. In either case, the VR counselor considers the:

* availability of comparable services and benefits to pay for all or part of costs;
* best value;
* customer's informed choice; and
* proximity of the facility to the customer's home and family.

If hospitalization is necessary, the VR counselor uses a hospital with which TWC has a contract. When selecting a hospital, the VR counselor and the customer must consider the:

* specialized services available (for example, for traumatic brain or spinal cord injuries or ear, heart, brain, or orthopedic surgery);
* composition of the patient population (for example, a comprehensive medical rehabilitation program primarily serving elderly stroke patients might not be appropriate for treating a young customer with a spinal cord injury);
* availability of additional services (for example, driver's evaluation and training, vocational evaluation, specialized orthotics, rehabilitation engineering); and
* availability and/or access to follow-up and aftercare.

### C-702-5: Hospital or Medical Facility Payments

Hospital and medical facility services are paid at the current payment rate established by the TWC contract and may not exceed the contract rate. Hospital services are paid based on a percentage of the hospital's usual and customary billing. Before authorizing payment, the VR counselor:

* consults the hospital contract comments in RHW to obtain the hospital's current payment rate; and
* obtains appropriate documentation that a medical service was provided.

For more information, see VRSM C-703-32: Specialized Physical Restoration Programs.

The following documentation is required for payment of a hospital or medical facility bill:

* Name of provider
* Documentation of service
* Record of hospital inpatient surgery or treatment
* Record of hospital inpatient diagnostic tests (laboratory, radiology, pathology)
* Record of hospital outpatient treatment, therapy, or diagnostic test
* Treatment, therapy, or diagnostic test report
* Information about employment supports for brain injury facility residential program progress (or staffing notes)
* Information about employment supports for brain injury facility nonresidential program progress (or staffing notes)
* Discharge summary and/or operative report

### C-702-6: Reduced Payment Agreement

When the customer's circumstances warrant, hospital contracts allow for payments to be less than or more than the contracted rate. A special reduced-payment agreement may be negotiated with a hospital under the terms of the hospital contract when the customer:

* is having a procedure with a projected high cost;
* is undergoing a series of surgical procedures; or
* has medical complications following surgery and is therefore having a hospital stay beyond the generally expected time frames associated with typical recovery.

The MSC consults with the VR Manager and completes the Form VR3422, Reduced Payment Agreement. The Form VR3422 is signed by both the MSC and an authorized hospital representative and a copy is placed in the customer's paper case file. The MSC then notifies the state office program specialist for physical disabilities.

### C-702-7: Length of Hospital Stay—Required Review

If the treating physician expects the recommended hospitalization to exceed 14 days, excluding inpatient comprehensive rehabilitation services and employment supports for brain injury, the VR counselor consults with the VR Manager and then consults with the state office program specialist for physical disabilities to ensure that the proposed treatment or surgery is an appropriate physical restoration service within the scope of VR services. VR Manager approval is required prior to authorizing hospitalization that will exceed 14 days.

When a customer requires hospitalization beyond the length of time to which VR originally agreed and VR payment will not continue, the VR counselor drafts the written notification and sends it to the VR Manager for approval. The VR counselor sends the approved written notification to:

* the customer;
* the hospital;
* the attending physicians; and
* all other parties concerned.

### C-702-8: Other Hospital Services

Hospital services that are not covered include:

* television rental;
* telephone calls;
* gourmet meals;
* cots; and
* guest trays and a private room, unless:
  + the physician orders it as medically necessary; and/or
  + no other room is available.

#### Blood

If a customer needs a blood transfusion, the VR counselor discusses with the customer donations from family and friends for replacement, if the physician has not done so. The VR counselor purchases blood when replacement from family and friends is not possible. When a medical procedure is scheduled, every effort should be made to obtain blood donations before the procedure.

#### Social Work Charges

VR pays hospital charges for social work services at the hospital contract rate when the services are prescribed by attending physicians.

These services are provided by contracts in either a residential or a nonresidential program.

## C-703: Policies for Services, Procedures, and Programs with Special Requirements

Listed below are physical restoration services or procedures that have special requirements. The VR counselor reviews the requirements throughout this chapter before including any of the services in the customer's individualized plan for employment (IPE) or IPE amendment.

The services are:

* adaptive or assistive technology;
* back surgery and steroid injections;
* bilateral total knee replacement (simultaneous);
* breast implant removal;
* cardiac catheterization or angiography;
* chiropractic treatment;
* cochlear implant;
* comprehensive medical treatment for spinal cord injury;
* dental treatment;
* discograms;
* electrical bone stimulators;
* eye surgery and treatment for eye conditions;
* eyeglasses and contact lenses;
* functional capacity assessments (FCA);
* functional electrical stimulation (FES) devices;
* hearing aids;
* home health and nursing-home care;
* intercurrent illness;
* low-vision aids
* medical assistive devices and supplies;
* nursing-home care;
* occupational therapy;
* orthoses and prostheses (see also FES devices, above);
* osteomyelitis;
* outpatient services;
* pain treatment;
* physical therapy;
* prescription drugs and medical supplies;
* procedures for pregnant customers;
* severe (morbid) obesity surgery;
* post bariatric surgery case management;
* speech therapy and speech training;
* spinal cord stimulator or dorsal column stimulator;
* weight loss programs;
* wheelchairs; and
* wound care.

These services or procedures are purchased when it is likely that they will enhance a customer's employability or capability to perform activities of daily living that will facilitate employment.

VR is the payer of last resort.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in VRSM D-203-2: Best Value Purchasing.

With respect to VR's responsibility for payment, after the customer's primary and/or secondary benefit coverage has been applied and the customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance or deductible due. VR payment does not exceed the insurance allowed amount or the allowable VR rate or VR contract rate, whichever is less.

### C-703-1: Back or Neck Injections or Neurotomy

The following procedures for back or neck pain require review by the LMC, consultation with the VR Manager, and consultation with the State Medical Director:

* Epidural steroid injections of the spine
* Facet injections of the spine
* Medial branch blocks
* Radiofrequency neurotomy

### C-703-2: Back or Neck Treatment

Back or neck surgery requires:

* review by the LMC;
* consultation with the State Office Program Specialist for physical disabilities; and
* VR Manager approval.

Spinal fusion surgeries involving three or more levels require:

* review by the LMC;
* consultation with the VR Manager; and
* consultation with the State Medical Director.

Back, neck, and spinal fusion surgeries may be purchased for a customer if the following criteria are met:

* The medical records must show evidence of:
  + abnormal radiographic imaging and clinical findings that correlate to the customer's symptoms;
  + a course of conservative treatment was completed if the treating physician has determined that conservative treatment is a reasonable treatment option for the customer's medical condition; or
  + other potential causes of the customer's symptoms have been ruled out; and
* The back or neck surgery is expected to remove the substantial impediment to employment by enhancing a customer's employability or capability to perform activities of daily living that will facilitate employment.

### C-703-3: Breast Implant Removal

Sponsorship of breast implant removal requires review by the LMC, consultation with the VR Manager, and consultation with the State Medical Director.

### C-703-4: Breast Reduction Surgery

To be approved, macromastia must be determined to be a substantial impediment to employment. Before surgery can be considered, there must be documentation that less-invasive therapeutic measures were tried first, including proper brassiere support, prescription medication, and/or physical therapy. Symptoms must be shown to have persisted despite reasonable therapeutic efforts. Reduction mammoplasty for macromastia may be purchased for a customer meeting the following criteria:

* Persistent functional impairment in two or more body areas, such as:
  + neck pain;
  + pain in the trapezius muscles (upper shoulder) and/or pain in the lateral cervical group of muscles (back of neck);
  + pain from brassiere straps cutting into shoulders;
  + upper back pain;
  + painful kyphosis documented by X-ray; and
  + chronic skin breakdown despite treatment;
* Evaluation by an orthopedic or spine surgeon noting that the customer's symptoms are primarily due to macromastia.

Breast reduction surgery requires review by the LMC, consultation with the VR Manager, and consultation with the State Medical Director.

### C-703-5: Cardiac Catheterization or Angiography

Cardiac catheterization may not be authorized as a diagnostic test before the IPE is written.

When stents are placed during a cardiac catheterization, the procedure is considered a medical service and is beyond the scope of a diagnostic procedure. All medical procedures, including cardiac catheterization that includes the placement of stents must be included as a planned service on the IPE.

Angiography should not be authorized before the IPE is written.

LMC review, consultation with the VR Manager, and consultation with the State Medical Director are required before authorizing cardiac catheterization and/or angiography.

### C-703-6: Chiropractic Treatment

Chiropractic treatment may be purchased for a customer only under the following conditions:

* A board-certified orthopedic or physical medicine and rehabilitation physician has submitted a written recommendation for the maximum number of allowed chiropractic treatments.
* The number of sessions does not exceed 12 sessions within 90 consecutive days, with a potential 8 additional sessions if symptoms are improving, for a total of 20 sessions. Additional sessions require consultation with the VR Manager and consultation with the State Medical Director.
* Only chiropractic manipulative treatment is purchased (MAPS 98940, 98941, or 98942).

### C-703-7: Cochlear Implant and Bone Anchored Hearing Aid Surgery

Surgery for a cochlear implant or a bone anchored hearing aid (BAHA) may be authorized when it is expected to correct or substantially modify a stable or slowly progressive hearing impairment that constitutes a substantial impediment to employment and/or training that is required for a specific employment outcome.

Documentation must address how the surgery will correct or modify substantially, within a reasonable period, the hearing impairment that constitutes a substantial impediment to employment.

TWC must use comparable benefits when possible when planning services related to hearing aids, cochlear implants, and BAHA for customers aged 18 and younger. To this extent, TWC may pay for any deductible, co-payments, and/or coinsurance for the provision of these goods and services if the total cost (insurance paid amount plus VR funds paid toward cost) does not exceed allowable VR contract rates.

Additionally, before planning surgical services, the customer must have:

* been diagnosed with a significant hearing loss and be unable to use a hearing aid effectively in the ear to be implanted;
* a stable or slowly progressive hearing impairment;
* good overall general health, as evaluated by a general history and physical examination;
* no evidence of problems that would preclude surgery or the aural rehabilitation program, including middle ear infection;
* for cochlear implant surgery:
  + an optimal inner ear structure, including an accessible cochlear lumen that is structurally suited to taking an implant; and
  + no evidence of lesions in the auditory nerve and acoustic areas of the central nervous system;
* for BAHA surgery, good inner ear function; and
* been evaluated by an otologic surgeon who is qualified to perform cochlear implant and BAHA surgeries.

The evaluation report completed by the otologic surgeon must include:

* diagnosis;
* recommendations for treatment; and
* prognosis.

The VR counselor must ensure that:

* the consultation with an LMC has occurred;
* for cochlear implant candidates, an effective aural rehabilitation program following surgery is available; and
* through counseling and guidance, the customer:
  + understands the prescribed treatment program and is willing and able to follow through;
  + acknowledges potential side effects; and
  + accepts that the device:
    - may be supplemented by a hearing aid in the other ear and/or use of other assistive listening devices; and
    - can create the perception of sound, but will not restore normal hearing.

A courtesy packet is sent to the following for consultation before planning the surgery:

* the VR program specialist for the deaf and hard of hearing (for all caseloads except Blind and Visual Impairment (BVI) caseloads); or
* the state office manager for blind services field support (for BVI caseloads).

The courtesy case packet includes the:

* medical, audiological, speech, and language evaluations and other reports as specified;
* justification of how the surgery will correct or substantially modify the substantial vocational impediment within a reasonable period;
* Form VR3101, Consultant Review (completed by the local medical consultant); and
* Form VR3110, Surgery and Treatment Recommendations (completed by the otologist performing the surgery).

Refer to the checklist on the Deaf and Hard of Hearing intranet page for a complete list of items to be included in the courtesy packet.

After the VR program specialist for the deaf and hard of hearing or the state office manager for blind services field support reviews the courtesy packet, a case note documenting the consultation is entered in RHW.

VR Manager approval is required for cochlear implant and bone-anchored hearing aid surgery.

All medical services related to the provision of cochlear implants and BAHA must be performed by licensed and/or certified:

* otologists; and
* audiologists.

### C-703-8: Dental Surgery and Treatment

To be allowable, dental corrective surgery or therapeutic treatment must be likely, within a reasonable period, to correct or modify substantially a stable or slowly progressive physical impairment that constitutes a substantial impediment to employment.

Dental treatment may be provided as:

* a means to address an intercurrent illness (for example, abscess or infection);
* a component of maxillofacial surgery; or
* needed treatment, as determined by the regional dental consultant, that allows the customer to participate in planned services within a reasonable period.

Dental treatment outlined above requires:

* regional dental consultant review; and
* VR Manager approval.

Routine dental care is not covered under VR. To be allowable, expenses for dental treatments must be shown to be directly related to a customer's employment goals as outlined in the IPE. The VR counselor must consider comparable benefits and ensure that least-cost, least-invasive procedures are considered first.

### C-703-9: Diabetes Insulin Pumps

VR does not purchase insulin pumps for the medical management of diabetes.

### C-703-10: Discograms

VR usually does not pay for a discogram, because the test has been found to be of limited diagnostic value. To approve a discogram, the VR counselor:

* obtains written justification for the discogram for the requesting physician;
* obtains review by the LMC;
* consults with the VR Manager; and
* submits the written justification along with the pertinent medical records to the State Medical Director for review and consultation.

### C-703-11: Dynamic Splinting Devices

Dynamic splinting devices may be prescribed for joint stiffness or contracture of the knee, elbow, wrist, finger, or toe. These devices are spring-loaded and adjustable to provide a low-load prolonged stretch while the customer is asleep or at rest. Dynamic splinting devices include, but are not limited to, such products as Dynasplint, EMPI Advance, LBM Pro-Glide, SaboFlex and Ultraflex. Consult with the program specialist for physical disabilities for the current clinical criteria and best value considerations.

### C-703-12: Electrical Bone Stimulators

An electrical bone stimulator may be authorized for a customer only when:

* the customer has:
  + a previous failed spinal fusion;
  + a multilevel spinal fusion; or
  + nonunion of a fracture six months or more from the initial fracture date;
* the customer has a prescription from the treating physician;
* the LMC determines that the request meets medical criteria for sponsorship; and
* best-value principles have been applied (that is, rent or purchase).

### C-703-13: Eyeglasses and Contact Lenses

To purchase single vision, bifocal, or trifocal glasses or contact lenses, the counselor obtains a prescription from an ophthalmologist or optometrist.

Frames must be the least expensive serviceable type available. The customer may supplement the additional cost for frames if their cost exceeds the MAPS maximum.

Lenses may have tint and/or be impact-resistant only when specified in the prescription.

Glasses may be purchased if needed to complete diagnostic studies.

Before purchasing contact lenses, the VR counselor:

* compares the cost of contact lenses with the cost of glasses; and
* applies best-value principles.

Note: Irlen lenses are not an approved purchase at this time.

### C-703-14: Low-Vision Services

A potential candidate for low-vision services is a customer whose vision cannot be normalized by conventional prescription glasses or contacts. Because expanding the provider base of low-vision specialists statewide is an ongoing need, the VR counselor contacts [the state office physical restoration program specialist](mailto:vr.rhw.maps@twc.texas.gov) if he or she learns of a new potential service provider. The VR counselor contacts the physical restoration program specialist also for information about how VR purchases low-vision services.

The primary goal for low-vision specialists and for VR is to ensure that customers have the opportunity for optimum visual functioning for vocational, educational, and independent living goals. However, because VR uses tax revenue for case service expenditures, the division must purchase the least expensive optical low-vision devices that meet the vocational needs of the customer. However, in some cases, the most expensive device might be the only one that meets the needs of the customer.

Note: The visual acuity to be used is the best corrected distance acuity. Best correction is the best visual acuity with a simple refraction (glasses or contact lenses), not with a low vision aid, such as a telescopic aid. An ophthalmologist or optometrist must:

* measure the visual acuity using the distance Snellen chart; or
* measure and then convert the measurement in writing to the distance Snellen equivalent.

### Low-Vision Provider Base

#### Procedure

While no licensure or certification for low-vision specialists exists, a growing network of service providers in the state exists who are well-trained, experienced, and provide excellent services. Some ophthalmological practices have a low-vision specialist on staff, but most low-vision specialists are licensed optometrists. Many are active members of the low-vision section of the Texas Optometric Association and have collaborated with VR via the state optometric consultant in the development of these guidelines.

### Optical and Nonoptical Low-Vision Devices

#### Policy

A wide range of services and items is available for people with low vision, from low-tech and low-cost approaches (for example, modifications in lighting, magnification, and contrast) to high-tech optical devices with higher costs (for example, single and compound optical systems). Only the optical devices are purchased through MAPS.

Other nonoptical items such as independent living aids, magnifiers, closed-circuit televisions (CCTV), and adaptive computer hardware and software are acquired and/or purchased as a non-MAPS specification in RHW (that is, warehouse supply, commercial requisitions, or contract purchases). The VR counselor contacts Customer Procurement and Client Services Contracting (CPCSC) to determine which purchasing mechanism to use.

#### Specific Referral Information for the Low-Vision Specialist

VR counselor can maximize the effectiveness of services by providing the low-vision clinician with information about the customer's:

* level of visual functioning for specific tasks and activities;
* specific visual problem areas as experienced in school, independent living, and/or on a job; and
* goals for greater independence in these areas.

Specificity of information is critical for the low-vision specialist to be able to direct the examination in terms of activities related to the customer's IPE goals. General referral information typically results in only general recommendations; specific referral information can produce pertinent recommendations related to the customer's IPE goals. It is recommended that a customer bring samples of materials that he or she wants to access visually to his or her meeting with the specialist.

#### The Low-Vision Evaluation

The CCS provides customer information to the low-vision provider before scheduling a low-vision evaluation. This preliminary step is critical in helping the provider to give VR information about how the customer's visual functioning relates to his or her planned goal.

Once the referral information has been provided and the customer's visual needs have been communicated, an initial low-vision evaluation is scheduled for the customer using MAPS Code DBS01 (low-vision evaluation—diagnostic/medical and functional components).

The DBS01 evaluation is a combination of:

* a diagnostic and medical component that must include a comprehensive medical history and eye examination (92014) with automated visual fields measurements (92083); and
* a low-vision refraction and magnification assessment with an individualized evaluation of the customer's functional use of residual vision in relation to the rehabilitation goal.

The second component is the unique component of the DBS01 low-vision evaluation. Because VR pays for this service, the information must be detailed in the provider's written report.

Note: The costs for the medical services component of the DBS01 evaluation are often covered by comparable benefits resources such as health insurance policies and Medicare. However, the functional component is rarely a covered service by any comparable benefits resource, and VR is the only financial participant to assist the customer with the costs. Comparable benefits for evaluations, if available, can be considered after the IPE is written.

From the evaluation, the low-vision clinician provides answers to the following questions about the customer's visual functioning:

* Is the current diagnosis consistent with the clinical findings?
* Can vision be improved with conventional corrective lenses?
* If so, what is the best corrected distance acuity in both eyes, with conventional lenses?
* What is the customer's near acuity, both single-letter identification and reading?
* Is this customer monocular or binocular?
* Does this customer have a problem with contrast sensitivity, and if so, how does this affect visual functioning and reaching rehabilitation and/or habilitation goals?
* Are there significant peripheral or central visual field losses?
* If so, how do these affect visual functioning and reaching rehabilitation and/or habilitation goals?
* Can distance vision be improved with telescopes, and if so, is a telescopic correction practical for this customer's vocational and/or daily living goals?

### Subsequent Low-Vision Evaluation Visits

#### Procedure

As rehabilitation and habilitation goals are refined, low-vision revisits may be indicated to determine further the types of nonprescription and/or prescription optical devices that could help the customer perform desired tasks and activities. The level of service required depends on the amount of time needed to accomplish subsequent evaluations.

It is important that the customer demonstrate the ability to use recommended optical devices at an acceptable level of efficiency. Unless the customer finds using the optics to be more efficient than not using them, it is unlikely that the devices will be used.

Examples include the following:

* Brief low-vision office visit—15 minutes (use MAPS 97535 x one unit). Usually, this visit is included in dispensing an optical device and is indicated for training a customer with a stock low-vision prescription.
* Intermediate low-vision office visit—30 minutes (use MAPS 97535 x two units). This level of service is mainly for working with the customer and a device that may be considered as a recommended prescription.
* Extended low-vision office visit—45 minutes (use MAPS 97535 x three units). An additional clinical evaluation after the first or subsequent visit may be indicated. Typically, the purpose is to finalize a prescription for an optical device, to continue the low-vision assessment because of complicating medical conditions or poor responses by the customer, or to provide a supplemental evaluation related to specific vocational, educational, or independent living tasks being addressed.

### MAPS Codes for Reimbursement for Optical Devices and Professional Services

Reimbursement to the low-vision specialist for prescribing, dispensing, and training for an optical low-vision device is based on the wholesale supplier's price apart from the specialist's professional service with the customer. A minimum processing fee (calculated as a designated percentage of the device's base cost) is added to the cost of the device to cover the low-vision specialist's costs, such as handling the prescription-ordering, verifying, shipping, and stocking.

VR reimburses the provider for professional time spent with the customer in designing a system of optical devices and in training the customer to use the system. This reimbursement method reflects the time and effort spent the low-vision clinician spent in developing an effective treatment for the VR customer.

#### Categories of Optical Devices and Price Ranges

The Low-Vision Packet for Eye Glasses and Low-Vision Recommendations is available by request from [the physical restoration program specialist](mailto:vr.rhw.maps@twc.texas.gov). The electronic version is in a printable format that may be shared with low-vision providers that recommend specific eyeglasses prescriptions and low-vision aids to ensure that both VR staff members and providers are sharing a common terminology and fee structure.

#### Handheld, Stand, and Other Stock Nonspectacle-Mounted Optical Devices

Handheld, stand, and other nonspectacle-mounted optical devices, known as V2600 devices, are nonprescription devices that can be purchased directly from a supplier as non-MAPS rehabilitation supplies or as a MAPS purchase through a low-vision specialist at the wholesale supplier's price plus 25 percent to the low-vision specialist.

These items are readily available and can be purchased over the counter by the public. VR staff may purchase these directly from a wholesale supplier as the least costly option. When purchased through a low-vision specialist, an additional 25 percent processing fee is paid on all stock items (including handheld magnifiers, handheld telescopes, stand magnifiers, and fit over filters for glare control and contrast enhancement). The base price is the cost that appears in the price list of a national supplier. Local VR offices have supplier price lists that can be used to verify that the service provider's charges do not exceed the MAPS maximum allowable payment.

A minimum of professional time is needed to train a customer to use these devices. For each classification of devices in the V2600 category, one DBS05 fitting fee can be authorized. For example, if the VR counselor approves one magnifier and one illuminated magnifier on the same date for the same customer, the VR counselor may authorize a total of two DBS05 fees (one for the non-illuminated magnifier and one for the illuminated magnifier).

Examples of devices include the following:

* V2600, illuminated stand magnifier (supplier's price + 25 percent)
* DBS05, dispensing fee
* V2600, handheld illuminated magnifier for home use (supplier's price + 25 percent)
* V2600, illuminated stand magnifier for workplace use (supplier's price + 25 percent)
* VR05, dispensing fee
* V2600, non-illuminated handheld magnifier (supplier's price + 25 percent)
* V2600, handheld telescope (supplier's price + 25 percent)
* DBS05, dispensing fee x 2

#### Single Lens, Spectacle-Mounted Low-Vision Devices

V2610 devices are prescribed and include all spectacle microscopes, microscopic bifocals (+5 diopters and over), doublet and triplet microscopes, Unilens, and prismatic half eyes. These devices are reimbursed at the supplier's price plus a 30 percent prescriptive service fee. Additionally, the low-vision specialist is reimbursed for a 92354 fitting fee for each single element low-vision device to cover the design, evaluation, and training costs involved. The VR counselor does not authorize an exam or evaluation, because the fitting fee covers the office visit and training. An additional exam may be provided and billed only if there is an additional goal that is being pursued and another prescription that is being considered.

Examples of these devices include the following:

* V2610, single element low-vision prescription (supplier's price + 30 percent); and
* 92354, fitting fee.

#### Spherical and Cylindrical Bifocal Microscopes

The low-vision clinician often must design and special order a prescription for the customer in bifocal or trifocal form, which includes cylinder, prism, and other special optics parameters. The reimbursement for these devices is per the V-codes as listed in MAPS.

Note: The 30 percent prescription service fee applies to V2610 items only.

Examples of these devices include the following:

* Monocular microscope with cylinder
  + V2025, deluxe frame for microscope
  + V2114, over +12D with cyl, per lens
  + V2100, plano lens/balance
  + V2699, polycarbonate lenses/pair
  + V2741, yellow contrast tint/per lens
  + 92354, single element fitting fee
* High add microscopic bifocal with cylinder
  + V2025, deluxe frame for microscopic bifocal
  + V2208, OD lens (-7 with -3 cyl)
  + V2211, OS lens (-10 with -4 cyl)
  + V2220, OD bifocal over +5D or greater
  + V2220, OS bifocal over +5D or greater
  + 92354, single element fitting fee

#### Telescopic and Other Compound Lens Systems

The more sophisticated and complex low-vision prescriptions are the bioptic, telemicroscopic, and reversed telescopic optical systems. These are spectacle mounted, include the customer's prescription, and often must include the use of filters. Advanced clinical skills and extended time are required for correct fitting. Extensive training is required for effective and efficient use of these prescriptive optical devices. Prisms for field awareness are also included in this category.

A fitting fee (92355) plus a 40 percent prescription service fee above the supplier's price are allowed for this category of devices. The VR counselor does not authorize an exam, because the fitting fee covers the office visit and training.

Note: The 40 percent prescription service fee applies to V2615 items only.

Examples of these devices include the following:

* V2615, bioptic 3x/monocular telescope (supplier's price + 40 percent)
* 92355, fitting fee for bioptic

#### Prism Awareness Systems

Custom prism awareness systems are unique ophthalmic prism designs. The low-vision specialist must provide the invoice from the lab that created the optics.

One example of this coding is an invoice for $400 for the prism, a $160 (40 percent) processing fee, $100 for the deluxe frame, and a $240 fitting fee. This allows for a maximum reimbursement of $900 for this system.

For prism (visual fields) awareness systems using Fresnel prisms (pronounced fre-NEL), V codes are used for the distance correction. Examples of the codes are as follows:

* V2101, right eye single vision
* V2101, left eye single vision
* V2025, deluxe frame
* V2784, polycarbonate lens (per lens)
* V2718, Fresnel prism / OS (per lens)
* V2718, Fresnel prism / OD (per lens)
* V2714, tint (both lenses)
* 92354, fitting fee

### Additional Guidance: Team Effort Leads to Successful Low-Vision Services

Discovering what works visually for a customer is a collaborative undertaking of multiple parties: the customer, the low-vision specialist, the customer's regular eye doctor, and VR staff. Shared communication is particularly important with low-vision services because the desired outcome of enhanced visual functioning is subjective in nature, and ultimately, success relies on the feedback from each customer.

If a customer is being followed by an ophthalmologist, the VR counselor confirms that no medical factors exist that might negate referral for low-vision services. The VR counselor links the low-vision specialist with the customer's ophthalmologist and requests that reports and recommendations be shared with the medical doctor.

Visual deficits such as progressive conditions and fluctuating loss of vision (for example, caused by diabetic retinopathy), diplopia (double vision), hemianopsia (visual field losses), and severe photophobia (light sensitivity) can complicate visual functioning and the customer's success with optical devices. However, these factors do not negate the need for low-vision services relevant to the customer's functional problems.

### C-703-15: Functional Capacity Assessment

A functional capacity assessment (FCA) is a comprehensive series of physical tests to determine a customer's ability to perform such functional tasks as walking, lifting, and stooping.

In most cases, an FCA is not required to determine the presence of an impairment and eligibility for services. Existing medical records should be used when possible. An FCA may be necessary at the completion of a physical restoration service to determine objectively a customer's physical capability to return to a specific job or achieve a specific employment goal.

To purchase a FCA, the VR counselor:

* obtains a prescription from the customer's physician or evaluating specialist; and
* verifies that the physician has provided medical care or evaluation of the customer within the past three months.

A licensed physical therapist, occupational therapist, or chiropractor must supervise the assessment directly. The assessment must include:

* a range of motion evaluation;
* a strength evaluation; and
* an endurance evaluation.

The licensed physical therapist, occupational therapist, or chiropractor completing the assessment must report the results of the FCA to the prescribing physician or evaluating specialist and the VR counselor. If needed, the VR counselor consults with the prescribing physician if the customer's safe work-capacity and work restrictions are unclear. The treating doctor who prescribed the FCA can review FCA report and communicate a release to work for final work restrictions. An FCA evaluation report is not a release to work.

### C-703-16: Gym Memberships and Home Exercise Equipment

Because of the potential risk of injury during unsupervised exercise, VR does not purchase gym memberships or home exercise equipment, including home equipment for water therapy or strengthening.

### C-703-17: Home Health Care Services

Providers of home health care must be licensed by the [Texas Department of State Health Services](https://www.dshs.texas.gov/).

Home health care that exceeds 30 sessions requires VR Supervisor approval.

Note: This policy does not apply to rehabilitation technology education services provided in the home.

Home health care services may be provided following VR-sponsored surgery if the following criteria are met:

* The customer is homebound or finds that leaving home requires considerable effort to go to the postoperative office visits and/or rehabilitative therapy.
* A physician order identifies the need for home health care.
* Home health care services are the best value to VR.

VRSM C-703-26: Rehabilitative Therapies, Outpatient Services has information about limitations.

### C-703-18: Intercurrent Illness

When a short-term illness or condition hinders VR services, the VR counselor provides acute medical care as necessary. This supplemental service is limited to such acute conditions as:

* infections or abscesses;
* pneumonia;
* appendicitis;
* ectopic (tubal) pregnancy;
* simple fractures; or
* minor injuries.

These conditions usually are short-term and do not alter the existing IPE. They may be documented as supplemental services with a service justification case note unless the case is in employment phase in RHW. If the case is in employment phase in RHW an IPE amendment is required.

### C-703-19: Mammograms, Pap Tests, and Colonoscopy

VR does not purchase mammograms, Pap tests, and colonoscopies for general cancer screening. Mammograms may be purchased if required by the surgeon for VR-sponsored breast reduction surgery. A Pap test may be purchased if it is required by the surgeon for VR-sponsored gynecological surgery. A colonoscopy may be purchased if it is required by the surgeon for a related VR-sponsored surgery. In each instance, the sponsored corrective surgery must be likely, within a reasonable period, to correct or modify substantially a stable or slowly progressive impairment that constitutes a substantial impediment to employment.

### C-703-20: Medical Assistive Devices and Supplies

Medically assistive devices and supplies may be purchased for a customer if the device or supplies are needed to meet the goals of the customer's VR program as set out in the IPE.

Before purchase, the VR counselor assesses and documents the following:

* Functional need in line with VR goals
* Expected functional improvement with device or technology
* Duration of use
* Issues related to use, such as compliance monitoring and maintenance
* Best value option has resulted in the following:
  + A less expensive option has been ruled out
  + Rental versus purchase has been evaluated

#### Medical Devices with Unlisted MAPS

New medical devices are usually designated as "investigational" or "experimental" because of nonexistent or limited independent research showing that the device is safe and effective for its designated purpose. These items usually have unlisted MAPS codes. TWC does not authorize the use of investigational or experimental medical devices.

See VRSM D-200: Purchasing Goods and Services, D-210: Medical and Psychological Services (MAPS).

### C-703-21: Orthoses and Prostheses

The VR counselor provides an orthosis or prosthesis to enhance a customer's employability or capability to perform activities of daily living that will facilitate employment.

#### Required Medical Examinations for Orthoses and Prostheses

Customers that have ongoing medical conditions that could affect the future ability to successfully use the orthotic or prosthetic device, such as diabetes or cancer (use Form VR3112, Cancer Diabetes Disability Medical Report), will need to have documentation from the appropriate medical provider indicating that the customer is compliant with treatment recommendations and that there is a good prognosis for successful orthotic or prosthetic use and return to employment.

For orthoses, a physician's examination is required before the purchase of an initial orthosis or if there is difficulty using the current orthosis.

For prostheses, an examination by a physician with a specialty in orthopedics or physical medicine and rehabilitation is required before the purchase of the first prosthesis.

If the customer has difficulty using his or her current prosthesis because of medical issues or problems with the residual limb, an orthopedic or physical medicine and rehabilitation specialist evaluation is required before planning the purchase of a second prosthesis. This specialty evaluation requirement for a prosthesis replacement does not apply to the following situations:

* The fit and use of the current prosthesis is compromised by damaged prosthetic components.
* A poor socket fit exists because of changes in weight or the normal physiologic changes that occur to the residual limb because of ambulation and activity with an initial prosthesis.

All providers of orthoses and prostheses must:

* be currently licensed by the Texas Board of Orthotics and Prosthetics;
* perform all measurements, fittings, alignments, and final checkouts;
* fabricate or directly supervise the fabrication of these devices; and
* provide final delivery and instructions for use.

Payments for orthoses or prostheses may not exceed MAPS.

#### University of Texas Southwestern (UTSW) Reviews

If the cost to VR for the prosthesis equals or exceeds $12,500 and the letter of specification contains no unlisted MAPS codes, the following is required:

* consultation with a VR Manager first; and
* University of Texas Southwestern (UTSW) technical review of the letter of specification.

#### Orthotic and Prosthetic Review Committee (OPRC)

If the letter of specification contains a prosthetic component with an unlisted MAPS code, consult with the VR Manager and then send the letter to the State Office Orthotic and Prosthetic Review Committee (OPRC). The component must be approved for purchase by the OPRC regardless of the cost.

An OPRC review is required even when the customer's comparable benefit is expected to pay for the major portion of the cost of the prosthesis or orthosis.

A letter of specification for a prosthetic that has an unlisted MAPS code does not require a secondary technical UTSW review.

If the L-code for a device or component is not listed in MAPS when the service record is generated, the OPRC must approve the purchase of the specialized device or component regardless of cost. OPRC approval for the purchase of a specialized device or component does not require an additional technical review by UTSW. Use the following procedures to submit a case to the OPRC for approval.

### Purchasing Orthoses and Prostheses

The VR counselor purchases the most basic orthotic or prosthetic device that allows a customer to meet his or her vocational needs. More technologically advanced devices or components may be purchased only if required by the customer's vocational needs as stated in the IPE. An orthosis or prosthesis is a medically prescribed item. The VR counselor is not required to obtain competitive bids. Payments for orthoses or prosthesis may not exceed MAPS.

See the Counselor Desk Reference, Chapter A2 Amputations for guidance.

Orthoses include:

* corsets;
* orthopedic shoes;
* braces; and
* splints.

Prostheses include:

* transhumeral (above elbow);
* transradial (below elbow);
* hand or fingers;
* hip disarticulation (full leg);
* transfemoral (above knee);
* transtibial (below knee); and
* foot or toes.

To purchase an orthosis or prosthesis for a customer, the VR counselor:

* obtains a physician's written prescription (a prescription is not required for the repair or replacement of a prosthetic or orthotic component);
* if purchasing a prosthesis, completes the Form VR3601, Upper Extremity Amputation Checklist or the Form VR3602, Lower Extremity Amputation Checklist and sends the identified section of the Checklist to the prosthetist for completion;
* obtains a letter of specification from the orthotist/prosthetist that includes:
  + Healthcare Common Procedure Coding System (HCPCS) codes;
  + the number of units;
  + item descriptions; and
  + itemized charges;
* obtains from the prosthetist or orthotist the medical or vocational justification for the components or devices selected. For a replacement, the VR counselor requests from the prosthetist or orthotist an identification of problems with the customer's current prosthesis or orthosis. The letter must describe the design and components of the current device fully. The letter must also:
  + identify problems that have limited the customer's ability to use the current device; and
  + explain the necessity and rationale of the proposed device;
* develops a service record for a recommended orthosis or prosthesis using the letter of specification;
* determines the need for a technical review of the letter of specification by the UTSW Medical Center Prosthetics—Orthotics Program or an approval by the VR OPRC for a specific component with an unlisted MAPS code; and
* determines whether the cost to VR for the prosthesis equals or exceeds $12,500 and the letter of specification contains no unlisted MAPS codes. If both of those circumstances exist, a UTSW technical review of the letter of specification is required.

If the letter of specification contains a prosthetic component with an unlisted MAPS code, then the component must be approved for purchase by the OPRC, regardless of cost. An OPRC review is required even when the customer's comparable benefit is expected to pay for the major portion of the cost of the prosthesis or orthosis.

A letter of specification prosthetic that has an unlisted MAPS code does not require a secondary technical UTSW review.

#### Procedure for University Southwestern medical Center UTSW Technical Review

To submit a letter of specification for a prosthetic for UTSW review, the VR counselor:

* uses the UTSW cover sheet that is found on the Medical Services intranet page, follows the instructions, and attaches required information; and
* documents in RHW the need for the required review and the submission date of the cover sheet and required information.

Upon receipt of the UTSW technical review report, the VR counselor shares the report with the prescribing prosthetist.

The VR counselor:

* discusses with the prosthetist the recommended changes to the letter of specification as identified by the UTSW review; and
* requests a revised letter of specification if the prosthetist agrees with the changes.

The VR counselor issues a service authorization for fabrication of the orthosis or prosthesis and verifies receipt before payment.

If an amended letter of specification cannot be negotiated, the prosthetist may submit additional information and the VR counselor may request a UTSW follow-up review of the case. The additional information must be substantive and pertain specifically to the customer. It should not be generic information or the same information provided in the original documents. The VR counselor requests the UTSW follow-up review using the procedure outlined above at an additional cost. Only one UTSW follow-up review is allowed. Questions about the UTSW report should be directed to the Medical Services team.

#### Procedure for Purchasing an Orthosis or Prosthesis with an Unlisted MAPS Code

If the L-code for a device or component is not listed in MAPS when the service record is generated, the OPRC must approve the purchase of the specialized device or component regardless of cost. OPRC approval for purchase of a specialized device or component does not require an additional technical review by UTSW. The VRC uses the following procedures to submit a case to the OPRC for approval.

The VR counselor:

* prepares a packet using the OPRC cover sheet that is found on the Medical Services intranet page, follows the instructions, and attaches all required information;
* documents in RHW the need for the required review and the submission date of the cover sheet and required information;
* reviews the OPRC decision entered in a case note in RHW (The decision includes a review and report of the state prosthetic consultant and is based on the medical and/or vocational necessity of the component.);
* gives the prosthetist a copy of the TWC state prosthetic consultant's report for review;
* submits a request for another review if the VR counselor, prosthetist, or orthotist has additional pertinent information that might affect the OPRC decision;
* contacts Medical Services to issue a service authorization for the fabrication of the orthosis or prosthesis if the component is approved by OPRC; and
* verifies the receipt of orthosis or prosthesis before payment.

#### Functional Electrical Stimulation Devices

Purchase of functional electrical stimulation (FES) for walking is limited to customers with spinal cord injury who have met the clinical criteria. The VR counselor must consult with the State Medical Director for a recommendation prior to purchase.

The VR counselor selects the most basic orthotic device that allows the customer to perform his or her tasks in the work environment. VR may consider the purchase of lower extremity FES devices (for example, the Bioness L300 or the WalkAide) only for customers:

* who have spinal cord injuries that meet specific clinical criteria in accordance with Centers for Medicare and Medicaid Services guidelines and who have had their cases reviewed by the State Medical Director;
* who can demonstrate a clear vocational need for the FES devices as compared to ambulation with an ankle foot orthosis or a knee ankle foot orthosis;
* who can demonstrate the ability to provide for the monthly maintenance and needed supplies; and
* whose case favors best value purchasing.

To request review of an FES device for a VR customer with spinal cord injury, the VR counselor:

* consults with the VR Manager;
* consults with the state office program specialist for physical disabilities about the clinical criteria; and
* submits a courtesy case to [vr.medicalservices@twc.texas.gov](mailto:vr.medicalservices@twc.texas.gov) for the State Medical Director to review.

Managers may not make exceptions to any part of the FES devices policy.

#### Warranties, Repair, and Maintenance of Orthoses and Prostheses

The provider agrees to replace, without cost to VR, defective parts and materials within 90 days of the customer's receiving the completed orthosis or prosthesis, excluding:

* evidence that the device or component has been altered by anyone other than the provider; or
* changes in the customer's condition that affect use of the device.

### Manufacture Warranty

When an orthosis or prosthesis requires repair, the VR counselor determines whether any of the repair cost and/or component replacement cost is covered by warranty before using VR funds. The provider must honor the manufacturer warranties and pay all costs associated with warranty replacement.

#### Extended Warranty

The customer must pay all costs associated with extended warranties.

### Maintenance

Before the purchase of an orthosis or prosthesis, the VR counselor discusses with the customer his or her responsibility to maintain, repair, and/or replace the orthosis or prosthesis. The VR counselor must discuss with the customer issues pertaining to specific maintenance costs of advanced technological components, such as the microprocessor knee unit.

### Repair

The VR counselor authorizes repair of the current orthosis or prosthesis unless the repair cost is more than 60 percent of the replacement cost. A prosthetist must submit the manufacturer's written repair estimate for advanced technological components, such as a microprocessor knee unit.

Labor charges are calculated at prevailing hourly rates for individual providers and must not exceed $50 per hour.

### Gait Training

The VR counselor purchases gait training for a customer with an above-knee prosthesis if the customer:

* has not used a prosthesis previously;
* will have a prosthesis that is different from the customer's previous prosthesis; or
* has not used a prosthesis for a prolonged period.

A prosthetist may provide training in the use of a below-knee prosthesis. If the prosthetist recommends additional training, the VR counselor arranges for prosthetic training from a qualified physical or occupational therapist.

A qualified physical or occupational therapist also may provide training in the use of an upper-extremity prosthesis.

### C-703-22: Osteomyelitis of the Extremities

Osteomyelitis is a bone infection that can cause an unstable medical condition with an uncertain prognosis. This condition may require complicated and extensive medical treatment.

VR considers sponsoring medical treatment for osteomyelitis only when:

* amputation of an extremity is recommended as a curative treatment; or
* the osteomyelitis condition occurs as a complication of a VR-sponsored surgery.

This requires review by the LMC, consultation with VR Manager, and consultation with the State Medical Director.

To authorize osteomyelitis treatment that is not a curative treatment, review by the LMC, consultation with the VR Manager, and consultation with the State Medical Director is required.

### C-703-23: Pain Treatment

Pain treatment may be purchased on a short-term basis only to improve a customer's functional ability that is necessary to achieve a well-defined employment goal set out in the customer's IPE. Since VR does not sponsor long-term medical treatment for chronic medical conditions, the VR counselor informs the customer that long-term pain treatment must be provided by comparable benefits or by the customer.

When a customer reports functional limitations related to chronic pain, the VR counselor:

* considers an orthopedic, neurological, or physical medicine and rehabilitation evaluation to determine whether the pain source can be treated with conventional physical restoration services;
* considers a functional capacity assessment followed by job placement services if no physical restoration treatment options exist and the customer wants to work despite the pain;
* screens for and coordinates treatment for comorbid psychological diagnoses; and
* obtains information from the physician about pain medication use and potential safety risks.

The VR counselor refers the customer to available comparable benefits to meet long-term treatment needs.

### C-703-24: Prescription Drugs and Medical Supplies

VR purchases medication that is prescribed to treat a specific diagnosis or condition for no more than three months. For any additional medication purchases an approval of the VR Supervisor must be entered into RHW. VR is the payer of last resort.

If eye surgery and/or treatment prescription coverage exceeds a three-month time frame, see VRSM C-703-36: Eye Surgery and Treatment for Eye Conditions for more guidance.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in D-203-2: Best Value Purchasing.

Customers must be referred to a comparable benefit program that includes prescription assistance at the time the purchase of the prescription is authorized.

Documentation of the referral must be included in the case file.

The customer's status and progress towards accessing comparable benefits to meet ongoing medication needs must be monitored.

When a customer is discharged from a medical rehabilitation facility or hospital that has an in-house pharmacy, VR may pay for a 30-day supply of the prescription drugs and medical supplies provided to the customer.

The purchase of prescription medication to treat a specific condition for longer than three months requires VR Supervisor approval.

### C-703-25: Procedures for Pregnant Customers

VR does not pay for medical services related to pregnancy.

The VR counselor assists the customer with child care planning to ensure her successful participation in the VR program.

### C-703-26: Rehabilitative Therapies

Rehabilitative therapies are physical restoration services that may be provided as a primary service or following other physical restoration services, such as surgery or injections.

To purchase a rehabilitative therapy, the VR counselor:

* obtains a prescription from the treating physician;
* provides the therapist with the vocational goal;
* monitors the customer's attendance and compliance with therapy; and
* assesses the functional improvement for the customer at the completion of the prescribed period of therapy.

If an extension of treatment is requested, the VR counselor:

* assesses and documents the customer's progress to date and potential for continued progress;
* documents how the additional requested therapy sessions are expected to contribute to achieving the employment goal; and
* obtains VR Supervisor approval for therapy exceeding 30 sessions or charges exceeding four units per session

Note: The 30-session limit for the life of the case applies to each individual therapy and not a combined number of therapies.

#### Outpatient Services

Outpatient services may include:

* physician visits; and
* nutritional services, when prescribed by a physician.

If the service provider requests an extension of treatment beyond the initial recommendation, the VR counselor assesses the customer's potential for continued progress. The assessment might involve reviewing treatment progress notes and/or contacting the physician, LMC, and/or provider. If continuing treatment is appropriate, the VR counselor:

* documents in the case file how continued services are expected to contribute to achieving the employment goal;
* may approve up to 30 visits or therapy sessions; and
* obtains the VR Supervisor's approval for extending treatment beyond 30 visits or therapy sessions.

#### Physical Therapy

Physical therapy is used to improve coordination, strength, and range of motion. This type of therapy:

* may be provided as work hardening and conditioning;
* is provided in 15-minute units of service (Multiple units make up one session.); and
* must be provided by a licensed physical therapist.

Note: A licensed physical therapist must evaluate the customer and develop the treatment plan. However, a licensed physical therapy assistant may work with a customer under the supervision of a licensed physical therapist.

#### Occupational Therapy

Occupational therapy improves the ability to perform activities of daily living, independent living, and work to achieve the goals of the IPE. This type of therapy:

* is provided in 15-minute units of service;
* has a single session comprising multiple units; and
* must be provided by a licensed occupational therapist.

Note: A licensed occupational therapist must evaluate the customer and develop the treatment plan; however, a licensed occupational therapy assistant may work with a customer under the supervision of a licensed occupational therapist.

#### Speech Therapy

Speech therapy improves expressive and receptive speech, auditory processing, and evaluation and training in the use of speech amplification devices. Speech therapy:

* is provided as one unit of the service per session (No time limit exists for a session.); and
* must be provided by a licensed speech and language pathologist.

#### Cognitive Therapy

Cognitive therapy improves memory, attention, social interaction, executive functions, visuospatial deficits, aphasia, and apraxia. Each therapy bills separately. Cognitive therapy must be provided by the following licensed providers:

* licensed psychiatrist or neuropsychiatrist;
* licensed psychologist or neuropsychologist;
* licensed occupational therapist; and/or
* licensed speech and language pathologist.

#### Vision Therapy

For more information on vision therapy, refer to VRSMC-703-36: Eye Surgery and Treatment for Eye Conditions.

### C-703-27: Surgery for Morbid Obesity

A customer is considered morbidly (severely) obese when his or her body mass index (BMI) is 40 or more. Morbid obesity is a disability if it results in an impediment to employment. Before considering bariatric surgery as a service for a morbidly obese customer, identify and document the customer's specific and substantial impediment to employment.

#### Procedure for Determining whether Morbid Obesity Results in a Substantial Impediment to Employment

To determine whether a customer has a substantial impediment to employment related to morbid obesity, the VR counselor uses the following assessment procedure:

1. Obtain documentation from a physician that shows the customer's height and weight and verify that the customer has a BMI of 40 or more;
2. Purchase an FCA to evaluate the customer's functional capabilities and accurately measure the customer's work capacity;
3. If the customer is employed, purchase a job analysis to determine the functional requirements of the customer's job and review the FCA and job analysis to determine whether the customer can perform the critical tasks of the job. If the customer can perform the critical tasks of the job, with or without a reasonable accommodation, there is no substantial impediment to employment related to severe obesity; and
4. If the customer is unemployed, use the results of the FCA to determine whether the customer can meet the physical demands of the job goal as defined in O\*NET or an equivalent resource. If the customer can perform the critical job tasks of the chosen realistic job goal, there is no substantial impediment to employment related to morbid obesity.

#### Nonsurgical Alternatives to Bariatric Surgery

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive alternative that meets the functional needs of the customer.

If a customer has a substantial impediment to employment related to morbid obesity, the VR counselor first determines whether any of the following nonsurgical options will remove the customer's substantial impediment to employment:

* Workplace modification
* Reasonable accommodation
* Assistive device
* Nutritional counseling
* Weight loss treatment (50–60 pounds in a six-month program)

Note: Before the VR counselor considers corrective surgery or therapeutic treatment, he or she must document that the surgery or treatment is likely, within a reasonable period, to correct or modify substantially the customer's impairment that is a substantial impediment to employment.

#### Procedure for Requesting Approval for Bariatric Surgery

If nonsurgical services will not remove the substantial impediment to employment, the VR counselor uses the following procedure to request approval to purchase bariatric surgery for a customer:

1. Obtains clearance for bariatric surgery and documentation of the medical stability of the customer's other conditions from a primary care physician or internal medicine specialist.
2. Arranges for a psychological or psychiatric evaluation with a bariatric focus that includes:
   * the Minnesota Multiphasic Personality Inventory (MMPI);
   * questions to the psychologist to determine the customer's motivation, family support, life stressors, coping ability, realistic expectations, and the presence of mental health diagnoses that may interfere with successful dietary compliance and weight loss; and
   * the need for medication management or psychological counseling to treat the underlying mental health condition (for example, anxiety or depression) that may interfere with successful dietary compliance and healthy lifestyle changes.
3. Refers the customer to an experienced bariatric surgeon for evaluation. Uses a bariatric surgeon affiliated with a bariatric center accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program if available. https://www.facs.org/search/bariatric-surgery-centers.
4. Instructs the LMC to review the customer's case.
5. If the bariatric surgeon and the LMC determine that the customer is an appropriate candidate for surgery, provides documentation for the customer's file that the customer successfully participated in a prebariatric surgery multidisciplinary program for at least three months.

#### Prebariatric Surgery Multidisciplinary Program

The purpose of a prebariatric surgery multidisciplinary program is to evaluate the customer's motivation to make lifestyle changes and comply with necessary dietary restrictions. The multidisciplinary program must have these four components: medical management, nutrition, behavioral modification counseling, and exercise components. If the bariatric surgeon has a prebariatric surgery program, the VR counselor verifies that the program has the four required components. The VR counselor coordinates and purchases missing components or creates a multidisciplinary program that uses independent providers. Refer to Tips for Creating a Multidisciplinary Prebariatric or Weight-Loss Program with Independent Providers (DOC) that can be found on the Medical Services intranet page. If the customer participates in a prebariatric surgery multidisciplinary program, the VR counselor must:

* monitor the customer's progress in the program;
* set appropriate expectations with the customer for participation, responsibilities, attendance, and goal attainment;
* discuss with the customer the consequences for noncompliance with the program;
* obtain monthly progress reports from providers or use the Prebariatric Surgery Program Progress Report; and
* if the customer successfully completes the prebariatric surgery multidisciplinary program, consult with the VR Manager and the State Medical Director to obtain a recommendation before proceeding with the bariatric surgery.

#### Postbariatric Surgery Case Management

Following bariatric surgery, the VR counselor:

* identifies the medical provider that is responsible for monitoring the customer's nutritional status and weight loss after surgery;
* verifies that the customer understands and accepts responsibility for complying with the postsurgical treatment plan; and
* monitors the customer's compliance with postsurgical instructions, dietary restrictions, and progress with weight loss.

#### Panniculectomy

Surgery to remove excess skin following weight loss (panniculectomy) is not a part of bariatric surgery services. A specific and separate impediment to employment must be established for VR to pay for a panniculectomy.

### C-703-28: Skilled Nursing Facility Services

Skilled nursing facilities services may be provided following VR-sponsored surgery if the following criteria are met:

* The customer's medical condition or lack of home care resources do not allow the customer to be discharged home.
* The physician's order identifies the need and that medical services cannot be provided by home health care services.
* Skilled nursing facility services are the best value to VR.

Skilled nursing facilities must meet the provider qualifications stated in VRSM D-200: Purchasing Goods and Services.

The VR counselor alerts the medical services coordinator at the time of physical restoration service coordination if the customer does not have adequate care resources following hospital or facility discharge.

### C-703-29: Spinal Cord Stimulator or Dorsal Column Stimulator

A spinal cord or dorsal column stimulator should be considered for chronic intractable pain when other treatment options have failed to provide adequate pain relief. If a spinal cord or dorsal column stimulator is recommended by the customer's treating physician, the VR counselor:

* obtains a psychological evaluation and has the report reviewed by the treating physician;
* obtains review by the LMC;
* consults with the VR Manager;
* consults with the State Medical Director to proceed with trial placement; and
* if the trial placement is successful in reducing the customer's pain, proceeds with the permanent placement of the spinal cord or dorsal column stimulator.

### C-703-30: Weight-Loss Treatment

VR sponsors weight-loss treatment for a customer under the following conditions:

* The customer has a BMI of 30 or more.
* The customer must lose 50 to 60 pounds in a six-month period.
* The reason for the recommended weight loss is:
  + to improve function or lessen the substantial vocational impediment caused by the primary disability;
  + to meet the surgeon's weight-loss requirement before surgery; or
  + to remove the substantial impediment to employment for a customer with severe (morbid) obesity when the loss of 50 to 60 pounds will remove the impediment.

Note: Obesity is not considered a primary disability unless the customer has a BMI of 40 or more, which meets the definition of morbid obesity.

To purchase weight-loss treatment for a customer, the VR counselor:

* verifies that the customer's BMI is 30 or greater;
* documents in RHW the reason that a weight-loss program is necessary;
* obtains a referral for weight-loss treatment from the customer's primary physician;
* obtains a psychological evaluation assessing motivation, family support, life stressors, coping ability, and realistic expectations to achieve and maintain weight loss. The psychological battery should include an MMPI;
* if the customer has underlying psychological diagnoses, such as anxiety and/or depression, ensure that the customer's psychological issues are being addressed through treatment before the start of the weight-loss program.

Weight-loss treatment must be multidisciplinary and include:

* medical supervision;
* nutritional education;
* psychological support and behavior modification; and
* an exercise program.

Weight-loss treatment can be provided by an established weight-loss program or by independent providers forming a multidisciplinary team. If an established weight-loss program does not have the four required components, the VR counselor provides the missing component services by using independent service providers.

Note: If the customer is participating in a fasting program, a physician must see the customer weekly, and regular laboratory studies are required.

Refer to Tips for Creating a Multidisciplinary Pre-Bariatric or Weight Loss Program with Independent Providers (DOC) that can be found on the Medical Services intranet page.

All weight loss plans and treatments require LMC review, consultation with the VR Manager, and consultation with the State Medical Director before the service begins.

For more information, see VRSM E-200: Required Approvals and Consultations.

The VR counselor contacts the state office program specialist for physical restoration for services not listed in MAPS.

The VR counselor provides counseling and guidance on the following issues and documents the conversations in RHW:

* The expectation of customer attendance and participation in weight-loss treatment
* The expectation that the customer will meet realistic weight-loss goals during treatment
* The consequences for noncompliance and the possible termination of treatment

The VR counselor must:

* monitor the customer's progress in treatment closely by getting monthly progress reports (the service provider may submit a report or use the Form VR3510, Weight-Loss Progress Report); and
* provide counseling as needed to promote a positive weight-loss outcome.

### C-703-31: Wound Care

When a VR counselor considers services for wound care that is a result of a surgery directly associated with a VR-sponsored surgery, the VR counselor discusses with the treating surgeon whether intervention is needed urgently. If it is not, the VR counselor requests that the LMC review the case on a priority basis. The VR counselor informs the LMC, the VR Supervisor, the MSC, and the program specialist for physical disabilities of the status of the case but does not delay services needed to promote the healing of the wound.

Wound care that involves an uncertain prognosis, such as abscess or infection, requires review by the LMC, consultation with the VR Manager, and consultation with the State Medical Director prior to authorizing treatment.

### C-703-32: Specialized Physical Restoration Programs

#### Fees for Specialized Programs

For consideration of potential sponsorship and subsequent fee negotiation, the VR counselor provides information on specific services not otherwise described below to the state office program specialist for physical restoration.

#### Cardiac Rehabilitation Facilities

For VR to sponsor services in a cardiac rehabilitation facility, the customer's physician must refer the customer to that facility.

A cardiac rehabilitation facility must meet the following criteria:

* Supervision by a cardiologist
* For each participant, an individualized, structured, progressive exercise program defined by a physician
* Continuous customer monitoring during exercise
* A physician must be available during exercise sessions
* A summary report with recommendations to the referring physician and to the VR counselor

#### Rehabilitation Hospital Programs Procedure

Rehabilitation hospital programs provide a coordinated and integrated service package that can include:

* medical supervision and treatment;
* physical and occupational therapy;
* prescription of prosthetic and/or orthotic appliances;
* psychological, social, and other services; and
* patient education.

Some programs also offer the following services:

* Driver education and training
* Vocational evaluation and/or vocational counseling
* Rehabilitation engineering

These are appropriate prevocational services for many customers with the most significant disabilities (for example, spinal cord injuries). For information on providing these services, see Back Disorders in VRSM B-308-1: Required Assessments and Policies for Selected Conditions.

The VR counselor confirms through a review of medical documentation that the customer is medically stable and that such medical complications as substantial decubitus ulcers, severe respiratory infection, and severe urinary tract infections have been treated successfully to allow the customer to participate fully in a comprehensive rehabilitation program. Refer to VRSM D-219: Health Care Professionals — Required Qualifications for criteria that apply to inpatient rehabilitation facilities.

### C-703-33: Fractures

VR does not provide medical care to treat a fracture for an individual who requires immediate medical or emergency services. VR services cannot be used to treat fractures that have not healed because unhealed fractures are not considered stable per 34 CFR 361.5(39)(i).

VR services may be considered only for eligible customers with fractures that have healed but have healed improperly (malunion or nonunion) and when these services are necessary to help the customer to obtain or maintain competitive, integrated employment. State Medical Director review is required to confirm the type and stability of the fracture prior to eligibility, as outlined in VRSM B-300: Determining Eligibility are met.

### C-703-34: Diabetes Self-Management Services

#### Considerations in Vocational Rehabilitation

When writing a plan for someone with diabetes, the VR counselor should consider several factors. First, it is important to maintain medical control of the diabetes through healthy eating, exercise, weight management, and use of medications. Therefore, these factors are key pieces of the rehabilitation plan.

A customer might need a flexible work schedule with frequent breaks to accommodate snacks and meals as well as insulin injections that are necessary to maintain proper blood sugar levels. Frequent breaks also may be needed to accommodate common functional limitations, such as low stamina. When discussing job options, the VR counselor and customer should consider the impact of jobs with irregular hours, long hours of work without breaks, and irregular physical exertion. Also, when discussing possible jobs, the VR counselor and customer should remember that the long-term complications of diabetes might not be visible for many years. A good rehabilitation plan takes these factors into consideration.

When the customer is deciding on an employment goal, the VR counselor should ask him or her to answer the following questions:

* Am I able to do the job with my current functional limitations?
* How will potential problems such as loss of vision, amputation, and kidney dysfunction affect my ability to perform on the job?
* Are there ways to accommodate these problems to allow me to do my job?
* Are there other jobs with the same employer that could be accommodated for my limitations?
* Will this job give me transferable skills that I need to find a closely related job that will accommodate my limitations?
* Does my employer know about long-term complications related to diabetes?
* Am I prepared for future complications? (Being prepared for future complications and how they might affect employment will help customers to select appropriate vocational goals as well as prepare them to develop confidence, competence, and independence.)

Customers with diabetes may have functional limitations in the areas of:

* physical stamina and endurance;
* standing and walking;
* motor coordination;
* manual and finger dexterity; and
* concentration.

#### Treatment and Management Options

The goal of treatment is to keep blood glucose near normal levels. Treatment may include following a healthy eating plan, exercising, testing blood glucose levels and other health metrics, and having daily insulin injections.

#### Complications of Diabetes

Diabetes can have several complications, including:

* blindness;
* heart disease;
* high blood pressure and stroke;
* kidney disease;
* nervous system disease;
* hearing loss;
* mental illness, including depression and diabetes distress;
* amputations; and
* dental disease.

### Adaptive Diabetes Equipment and Supplies

To maintain consistency and to ensure that the VR counselor has a thorough working knowledge of adaptive diabetes equipment, the VR counselor must obtain a written recommendation before purchasing adaptive equipment. The recommendation also must include who is to provide training on the equipment.

The diabetes educator, a physician, or the VR diabetes program specialist can provide the recommendation. The equipment may include talking blood glucose monitors and supplies, blood pressure monitors, weight scales, and other diabetes equipment that can be tied to the customer’s individualized plan for employment or independent living plan.

### Training on Blood Glucose Meter and Insulin Drawing Devices

The customer can receive training on equipment from:

* a qualified diabetes educator listed in RHW; or
* the VR diabetes program specialist.

### Services Provided by Diabetes Educators

Diabetes educators have appropriate licensing as health professionals. Professional licensing includes certified diabetes educator, registered nurse, or dietician, preferably with specialization and certification in diabetes education. Diabetes educators are certified by the diabetes program specialist.

The diabetes program is designed for individuals with severe disabilities who need one-on-one training primarily. Occasionally, group training may be arranged when appropriate and when it will benefit the customers of a region.

VR counselors must follow the guidance below.

1. The VR counselor assesses whether community diabetes education programs, including free or low-cost programs, are available. Alternatively, the VR counselor uses the comparable benefits to arrange diabetes self-management education training through recognized or accredited diabetes programs in local hospitals or health centers. Customers whose disability does not impact their ability to participate in traditional group training receive diabetes services at this level.
2. If the customer's disability is severe and the customer could benefit from specialized diabetes education with an understanding of self-management adaptive techniques, equipment, tools or teaching skills, then referral to a contracted diabetes education provider through the diabetes program is recommended. (Severe disabilities include blindness, cognitive issues, or any disability that might make participation in group diabetes education difficult.)
3. If the customer has participated in community diabetes education and is still struggling to manage the diabetes, referral to a contracted diabetes education provider is recommended. For example, when the customer has participated in community diabetes education, but he or she continues to have issues, then one-on-one education by a contracted provider may be needed to identify reasons for the mismanagement. The VR counselor might consider whether the customer's struggle is with diabetes knowledge and skills, or if it could be caused by depression, anger, or other issue for which a licensed professional counselor should be contracted.

Diabetes educators may provide services in evaluation and training:

* on tools and techniques for managing diabetes;
* on insulin-drawing devices and blood glucose monitors; and
* for education needs (for example, meal planning and injection techniques).

Diabetes educators also provide the following services:

* Education on diabetes health maintenance
* Training on diabetes education services
* Information about resources that are available in the customer's area and how to access those services

See the VR Standards for Providers Chapter 7: Diabetes Self-Management Education Services for contract requirements for diabetes educators.

### C-703-35: Bilateral Total Knee Replacement (Simultaneous)

Knee replacement surgery may be considered when conservative treatment has failed to resolve an impediment to employment created by pain or loss of function in the knee. Simultaneous bilateral total knee replacement requires the review of the LMC, consultation with the VR Manager, and consultation with the State Medical Director.

### C-703-36: Eye Surgery and Treatment for Eye Conditions

The purpose of eye medical services is to assist eligible VR customers with a visual impairment to prevent the onset of legal blindness or make an improvement in their visual impairment, and to allow them to maintain or seek employment and remain independent in their jobs.

Federal law requires that medical services (including corrective surgery or treatment) that are sponsored or supported by VR services must:

* have a direct effect on the customer's functional ability to perform the employment goal, or support other needed VR services; and
* be likely, within a reasonable period, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment.

34 CFR 361.5(39)(i)

For more information, refer to VRSM C-701: Professional Medical Services.

#### Eye Surgery Process

Before moving forward in completing the IPE and/or amending the IPE, and authorizing eye medical services, the VR counselor must:

* document how the customer's substantial impediment to employment will be addressed by the proposed eye surgery or treatment in a ReHabWorks (RHW) case note;
* obtain a written recommendation for planned eye medical services with current (within six months) procedural terminology codes from the surgeon or physician for the recommended procedures using the Form VR3109, Eye Surgery and Treatment Recommendation form or eye medical records (within 6 months);
* have appropriate reviews or approvals required, completed, and documented in RHW (if applicable); and
* determine whether the eye surgery or treatment will be coordinated by a unit VR team or the medical services coordinator (MSC).

After the completion of the above, the VR counselor must place the appropriate eye medical services on the IPE/IPE amendment before the eye medical services are completed.

The surgeon or physician must complete all relevant areas of the Form VR3109, Eye Surgery and Treatment Recommendation form that are relevant to the customer's eye condition. If information is missing, VR staff must return the form to the surgeon or physician for completion.

#### Local Medical Consultant Reviews for Eye Treatment and/or Eye Surgeries

Due to the nature of eye surgeries and treatments being low-risk procedures and to create more efficient and timely services for customers, a local medical consultant review is not required for eye surgeries or treatments. For more information, refer to VRSM C-701-2: Medical Services Required Review and Approvals Policy.

#### State Consultant Reviews or Consultations for Eye Treatment and/or Eye Surgeries

TWC's state ophthalmological consultant and state optometric consultant are available to address and answer questions pertaining to their respective eye specialties. State consultants do not address internal VR policy issues such as eligibility determinations for VR services. VR policy questions must always be directed to the appropriate supervisory or management channels.

For more information, refer to VRSM C-701-2: Medical Services Required Review and Approvals Policy and VRSM B-101-7: Consultants.

#### Determining Whether a State Consultant Review Is Needed

Before writing the IPE/IPE amendment and any time during the case progress, the VR counselor may choose to consult the state optometric consultant or the state ophthalmological consultant with questions. The VR counselor must use the Form VR2351, Request for MAPS Consultation for Visual Services. The VR counselor completes the Form VR2351 with relevant questions for the state consultant and sends all relevant medical records and documents that have been gathered.

State consultant reviews or consultations may be requested by the VR counselor if there are:

* conflicting or unclear eye medical records or documents;
* questions on recurring eye medical treatments;
* procedures not listed in MAPS;
* questions on requests from medical providers for a higher than normal cost; or
* requests for fees that exceed MAPS fees.

#### State Consultant Review for Eye Conditions

The table below provides guidance on when a state ophthalmological consultant review is required:

|  |  |
| --- | --- |
| **Eye Condition** | **State Ophthalmological Consultant Review Required** |
| Any surgery | If more than one surgeon is recommended on any procedure |
| Cataracts | If, more than two per eye, past cataract surgeries have occurred  If any lens other than a standard intraocular lens is recommended |
| Corneal Transplant | No |
| Diabetic Retinopathy | After 12 injections (per eye) and/or if injection cost is more than $300 per injection |
| Glaucoma (mild/moderate) | No |
| Glaucoma (advanced) | After 12 injections (per eye) and/or if injection cost is more than $300 per injection |
| Keratoconus (not severe) | No |
| Keratoconus (severe) | After one previous crosslinking procedure has occurred |
| Macular Degeneration (Wet or Dry) | After 12 injections (per eye) and/or if injection cost is more than $300 per injection |
| Ocular  Prosthesis Replacement | No |
| Retinal Detachment | No |

For additional approvals and consultation guidance, refer to VRSM E-200: Summary Table of Approvals, Consultations, and Notifications.

When a consultation is required, the state ophthalmological consultant will provide a recommendation to the VR counselor. Any decision contrary to the state ophthalmological consultant’s recommendation requires approval from the Deputy Division Director of Field Services Delivery.

For more detailed information on common eye conditions, treatments, or surgery, refer to the Counselor Desk Reference (CDR), C2: Blind and Visual Impairments.

#### Steps to Completing a State Ophthalmological or State Optometric Consultant Review

If a state consultant review is requested or required, VR staff must submit an email request to:

* [vr.mapsinquiry\_blindservices@twc.texas.gov](mailto:vr.mapsinquiry_blindservices@twc.texas.gov) ; and
* include in the subject line: State Consultant Review and Case ID number.

VR staff must include the Form VR2351, Request for MAPS Consultation for Visual Services, and the following information and attachments with the email:

* Purpose of the request
* Customer's case ID
* Pertinent medical records
* Form VR3109, Eye Surgery and Treatment Recommendation form (if completed)
* Form VR2006E, Interagency Eye Examination Report (if completed)

The Eye Surgery/Treatment Consultant Review checklist is available on the Medical services intranet page and may be used as a guide of what must be included in the email.

VR staff documents the outcome of the state consultant review in a case note in RHW using the drop-down case note title of Consultation/Review, Add to Topic: Eye Medical.

#### State Office Program Specialist Staffing

Eye surgeries with complex procedures may need more consultation by state office. State office program specialists are available if VR staff that have questions that cannot be answered by regional staff.

VR staff contacts the state office program specialist for blind services if the counselor has:

* questions regarding a need for an eye surgery;
* questions regarding the eye surgery process; or
* questions in general regarding blind services policy and procedure.

VR staff sends emails to [BVI\_staffing@twc.texas.gov](mailto:BVI_staffing@twc.texas.gov) with the subject line: Staffing Request and Case ID number.

VR staff contacts the state office program specialist for physical restoration at [vr.mapsinquiry\_blindservices@twc.texas.gov](mailto:vr.mapsinquiry_blindservices@twc.texas.gov) with the subject line "MAPS Request and Case ID number" if:

* codes are not listed in MAPS;
* the code is listed as $0; or
* codes end in "99" or the letter "T."

VR staff members must copy their immediate supervisor on all consultation requests. Refer to VRSM E-200: Summary Table of Approvals, Consultations, and Notifications for more information.

#### Eye Prescriptions

Eye prescriptions are prescribed by a physician for pre– and post–eye surgeries and also to assist in controlling an eye condition so that vision does not worsen. Some eye conditions could be eye infections, eye inflammation, or treat the eye pre- and post-surgery. Some eye conditions are temporary, and in most cases eye drops will resolve the issue quickly. Typically, glaucoma is treated with prescription eye drops first. Eye conditions, such as glaucoma, are chronic and may require prescription eye drops for a period longer than three months. For most eye surgeries, eye drops are not used for more than a month, with an exception being steroid drops for corneal transplants.

For any eye drops that a physician is recommending for treatment that exceeds a three-month time frame, VR Supervisor approval is required.

For more information, refer to VRSM C-703-24: Prescription Drugs and Medical Supplies and VRSM E-200: Summary Table of Approvals, Consultations, and Notifications.

#### Eye Injections

Certain retinal treatments are treated successfully using intravitreal injections. Injections are treatments that are used most commonly to treat diabetic eye disease, macular degeneration, and retinal vein occlusion. Treatments of eye injections that are conducted in the physician's office using a local topical anesthetic or a local subconjunctival lidocaine or retrobulbar injection may be coordinated by the VR Counselor/Rehabilitation Assistant (RA) team.

Customers may legitimately need continued injections to maintain their vision. Eye injections decrease the possibility of permanent vision loss, so maintaining a regular schedule of treatment to suppress the disease is critically important for maintaining long-term good vision. Once a customer is stabilized, a scheduled treatment plan may be implemented. Most commonly, an average of 12 injections per eye may be needed to stabilize an eye condition. After 12 injections per eye are completed, a state ophthalmological consultant review is required to reassess the customer's eye treatment.

Eye injections are not considered a prescription, but rather a physician recommended treatment.

For more information on State Consultant review requirements, refer to the State Consultant Review for Eye Conditions table above.

#### Documenting Eye Injections

The VR counselor must have regular counseling and guidance with the customer regarding applying for comparable benefits and payment options since the customer may need continued eye injections to maintain his or her eye health indefinitely. VR staff must enter case note(s) in RHW to document the effect and improvement of the customer's progress with the treatment of eye injections.

#### Exemption from MSC Coordination of Eye Surgery/Treatment

If the recommended surgery or procedure will be conducted in a physician's office or ambulatory surgical center with a local topical anesthetic or a local subconjunctival lidocaine or retrobulbar injection, it is exempt from MSC coordination. The VR counselor/RA team may coordinate these medical services at the local office level. A case note entered into RHW must clearly document the appropriateness of the VR counselor/RA team coordinating the eye medical service. All corresponding medical records and/or evaluations must be placed in the paper case file.

Note: For the purpose of VR service delivery, local anesthesia is considered a local topical anesthetic or a local subconjunctival lidocaine or retrobulbar injection that is used during in-office procedures with no anesthesia staff present and does not require a separate billing from an anesthesiologist or certified registered nurse anesthetist (CRNA).

If the surgery or treatment is required to be sent to the regional MSC, frequent communication between the MSC and VR counselor/RA team is advised.

Follow guidance in VRSM C-701-3: Coordinating with the Medical Services Coordinator.

#### Discharge Procedure for Eye Surgeries

Because most eye surgeries and treatments are performed in a physician's office, eye surgeries are exempt from the requirement to contact the customer at discharge. The VR counselor must contact the customer as soon as possible to provide counseling and guidance and to get an update on the procedure. The VR counselor then documents the conversation in RHW.

#### Corneal Transplants

Corneal transplant, also called a keratoplasty, is a surgical procedure in which the corneal tissue is replaced with donor tissue. Most of the time, corneal transplants are conducted as an outpatient procedure. If the procedure will be completed using general or local/MAC anesthesia, the case should be coordinated through the MSC.

If the procedure is completed using a local topical anesthetic or a local subconjunctival lidocaine or retrobulbar injection, the VR counselor/RA team completes the following steps for the Corneal Transplant process.

#### Corneal Transplant Process

1. Contact the facility to determine which eye bank the facility will use.
2. Call the eye bank directly to request a copy of the invoice as soon as it becomes available. The eye bank invoice is required before a service authorization is issued.
3. The invoice amount is typically set at zero since the authorized payment varies depending on the source of the tissue. Payment for the donor tissue is based on the eye bank's invoiced amount. VR does not pay for shipping, handling, or other processing fees.
4. VR staff must obtain a copy of the original eye bank invoice. Do not pay from the hospital or facility invoice. Retain the invoice in the customer's case file. The service record and service authorization for a MAPS purchase must be completed once the service is approved but before the service is ordered. The service authorization must only be completed once the actual eye bank invoice is received.

The invoice from the eye bank will not be received until immediately before the service. This delay occurs because corneal tissue is only shipped to the facility immediately before the surgery. The eye bank cannot ship the donor tissue until the last minute and there is no way of knowing the actual cost until the tissue is available and ready to be shipped.

It is necessary for VR staff to work closely with the eye bank in advance of the planned surgery to ensure the invoice is received as soon as possible. Typically, VR staff receives the invoice the day before the scheduled surgical procedure.

1. Once the eye bank invoice is received, send an email to [vr.mapsinquiry\_blindservices@twc.texas.gov](mailto:vr.mapsinquiry_blindservices@twc.texas.gov) to request to open V2785 in the amount shown on the invoice. The email must confirm that the requested amount does not include shipping, handling, or other fees.

For example: Please open V2785 in the amount of $xxx. This amount is the eye bank invoice amount without shipping or handling.

1. A medical services team member will open V2785 in the requested amount. You will be notified when the MAPS code has been opened.
2. Complete the service record and service authorization.
3. Required documentation must be completed in RHW before changing the amount requested.

#### Codes for a Corneal Transplant Procedure

* Keratoplasty lamellar (CPT 65710)
* Keratoplasty penetrating (CPT 65730)
* Keratoplasty penetrating in aphakia (CPT 65750)
* Keratoplasty penetrating in pseudophakia (CPT 65755)
* Keratoplasty (corneal transplant) endothelial (CPT 65756)
* Tissue code for facility (FAC 67530)
* Donor tissue (V2785)
* Backbench preparation of corneal endothelial allograft prior to transplantation (+ 65757)

Add-on codes apply to work that is always conducted in conjunction with a primary procedure. VR staff cannot bill for CPT code 65757 unless VR staff also bills for CPT code 65756.

For more information on corneal transplants, refer to Counselor Desk Reference CDR C2: Blind and Visual Impairments.

#### Vision Therapy

If vision therapy is recommended, consultation with the state optometric consultant is required.

The VR counselor must include the following in the state optometric consultant consultation request:

* Completed Form VR2351, Request for MAPS Consultation for Visual Services
* General medical and ophthalmological and/or optometric exams, and other relevant reports
* VR counselor observations of and knowledge about the customer's visual and perceptual difficulties
* Name and telephone number of a potential service provider, if known

VR staff then emails all the requests to [vr.mapsinquiry\_blindservices@twc.texas.gov](mailto:vr.mapsinquiry_blindservices@twc.texas.gov) and add "Vision Therapy Consultation" to the subject line.

For more information on vision therapy, refer to VRSM C-703-26 Rehabilitative Therapies.

## C-704: Durable Medical Equipment

This section provides policies and procedures for purchasing durable medical equipment (DME), including hearing aids, which are medical assistive devices and supplies. VR is the payer of last resort.

The VR counselor applies the policies in VRSM C-704-1 through VRSM C-704-11 to all medical assistive devices and supplies, regardless of category.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in VRSM D-203-2: Best Value Purchasing.

With respect to VR's responsibility for payment, after the customer's primary and/or secondary benefit coverage has been applied and customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance, or deductible due. VR payment does not exceed the insurance allowed amount or the allowable VR rate or VR contract rate, whichever is less.

Medical assistive devices and supplies fall into three categories, which have policies and procedures that are specific to each. The categories are as follows:

* Medical assistive devices and supplies, noncontract
* Medical assistive devices and supplies, contract
* Medical assistive devices and supplies, nonspecific

### C-704-1: Bids and Specifications

Bids are required when a single purchase is expected to exceed $10,000, unless the item is under contract or listed in MAPS. The VR counselor follows the purchasing guidelines in VRSM D-200: Purchasing Goods and Services in addition to the applicable guidelines in this section.

The service authorization must include a complete description of the items to be purchased. See the ReHabWorks Users Guide.

### C-704-2: Purchases from Hospitals

Medical assistive devices and supplies that are purchased from contracted hospitals must be:

* listed on the hospital invoice; and
* paid for under the terms of the hospital contract.

To determine the proper procedure to purchase items not listed here, the VR counselor contacts the State Office Program Specialist for Physical Restoration.

### C-704-3: Ownership of Medical Assistive Devices

Medical assistive devices purchased for a customer by VR are the property of the State of Texas.

### C-704-4: Required Review before Purchase

DME with a service authorization over $5,000 requires review by the State Office program specialist for rehabilitation technology.

The VR counselor utilizes the assistive technology specialist (ATS). The ATS:

* prepares a packet using the DME coversheet, follows the instructions, and attaches all required information;
* submits the packet to the PSART mailbox: [PSART@twc.texas.gov](mailto:PSART@twc.texas.gov);
* documents in RHW the need for the required review and the submission date of the cover sheet and required information; and
* reviews the DME decision entered in a case note in RHW, resolves any issues with the vendor, and informs the VR counselor when the review is completed.

### C-704-5: Procedures for Purchasing Contracted Medical Assistive Devices, Excluding Hearing Aids

The VR counselor uses the following procedure to buy all contracted medical assistive devices, except for hearing aids.

1. The VR counselor obtains a prescription, puts a copy in the case file, and documents the action in a case note.

Note: Written recommendations are required for the initial purchase of all contracted medical assistive devices and replacement items.

1. The VR counselor reviews and follows the item-specific requirements for the following assistive devices:
   * Rehabilitation or hospital beds;
   * Patient lifts;
   * Manual wheelchairs;
   * Power wheelchairs;
   * Scooters;
   * Assistive devices for the bathroom;
   * Seating and positioning systems; and
   * CPAP or BiPAP.

After an initial prescription is received, the VR counselor obtains specifications (type, size, and special features) by arranging for the customer to be evaluated by:

* a physiatrist;
* a pulmonologist;
* a physical or occupational therapist;
* a rehabilitation engineer; or
* an assistive technology professional.

### C-704-6: Replacement Wheelchairs

The VR counselor obtains an estimate of the cost for refurbishing the original chair from the local provider of wheelchair repair services.

The VR counselor applies best value principles in considering whether repair or replacement is the more cost-effective course.

When purchasing a replacement chair, the VR counselor gets the customer's current (within six months) prescription and a reevaluation by a physiatrist, a physical therapist, or an occupational therapist.

Repairs do not have to be purchased from a contract provider. For information on wheelchairs, scooters, and other repairs, see VRSM C-704-9: Medical Assistive Devices and Supplies—Noncontract, Noncontract Items Requiring Special Consideration.

### C-704-7: Documentation and Fees

Contractors agree to provide DME rates and instructions outlined in VR Standards for Providers Chapter 8: Durable Medical Equipment, 8.5 Methodology for Payment.

VR is the payer of last resort.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in VRSM D-203-2: Best Value Purchasing.

With respect to VR's responsibility for payment, after the customer's primary and/or secondary benefit coverage has been applied and customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance or deductible due. VR payment does not exceed the insurance allowed amount or the allowable VR rate or VR contract rate, whichever is less.

Payment for fabricated goods that are invoiced must be based on the vendor-provided specification approved by the VR counselor. This includes:

* payment for development of schematics, drawings, or other required descriptive materials;
* installation;
* setup and training;
* written instructions on use and maintenance; and
* the availability of self-repair information, parts, warranty, and post-warranty repair.

The VR counselor is authorized to pay the provider for the entire functional unit upon receipt of an invoice. The invoice must include the current MSRP and discount rate for the item purchased. A copy of the MSRP list or order form must be attached to the invoice.

VR staff:

* verifies with the customer that the goods or services were provided; and
* documents in the case file that the goods and services were provided before payment.

### C-704-8: Contracted Goods and Services

#### Procedure

Contract administration staff solicits and manages contracts for VR goods and services. Some goods or services must be purchased under contract. Before purchasing a good or service, the VR counselor uses RHW to find out whether a contract is required. When the service authorization is generated, RHW assigns the contract number based on the vendor and the type of purchase. Refer to the ReHabWorks Users Guide: E-200: Case Service Records for more information about creating a service record.

Customer goods and services that are purchased under a contract include, but are not limited to:

* rehabilitation technology;
* employment services such as:
  + job readiness;
  + job placement;
  + job coaching;
  + job skills training;
  + supported employment services;
  + self-employment services;
* hospital services;
* inpatient or outpatient services; and
  + supported self-employment services;
* employment supports for brain injury for VR;
* residential services;
* nonresidential services and equipment, including:
  + some medical equipment;
  + DME;
  + manual wheelchairs (fully functional chairs);
  + scooters;
  + seating and positioning systems;
  + patient lifts;
  + power wheelchairs (fully functional chairs);
  + hospital beds;
  + power units and controllers; and
  + hearing aids; and
* vehicle modifications

### C-704-9: Medical Assistive Devices and Supplies—Noncontract

The following procedures apply to noncontract medical assistive devices and supplies. See Examples of Medical Assistive Devices and Supplies, Noncontract for a list of examples in this category.

1. The VR counselor determines whether a written recommendation or prescription is required. Written recommendations are required for:
   * the initial purchase of medical assistive devices and supplies; and
   * replacement items when the medical condition is progressive.
2. If required, the VR counselor obtains and places in the case file a written recommendation and/or prescription from:
   * a physician;
   * a physician assistant;
   * an advanced practice nurse;
   * a dentist; or
   * an optometrist.

Note: When the written recommendation and/or prescription do not describe the item, the VR counselor obtains a letter of specification from an appropriate certified paramedical specialist (physical or occupational therapist, orthotist, or prosthetist).

1. The VR counselor follows procedures outlined below in Noncontract Items Requiring Special Consideration, if applicable.

#### Noncontract Items Requiring Special Consideration

Noncontract items requiring special consideration are listed in the following table.

|  |  |
| --- | --- |
| **Item** | **Required Consideration** |
| Dentures or dental appliances | Manager's approval is required. |
| Prescription drugs | A prescription from a physician (MD or DO), physician assistant, or advanced practice nurse, or the prescription number from the named pharmacy, is required. |
| Repairs | Repairs to prosthetic or orthotic devices do not require a medical professional's recommendation or prescription. Payment for repair labor charges must not exceed $50 per hour. |
| Transcutaneous electrical nerve stimulator | The device must be rented for 7–14 days before the VR counselor may purchase it.  If the VR counselor purchases it, the vendor must agree to apply the rental fees to its total cost. |

### C-704-10: Hearing Aids

VR counselors may authorize hearing aids when they are expected to improve the customer's ability to participate in employment and/or training that is required for a specific employment outcome. Hearing aids are purchased to benefit a customer who is deaf, hard of hearing, DeafBlind, hearing impaired, or who would otherwise benefit from hearing aids as recommended by a licensed audiologist or hearing aid specialist. Recommendations from a licensed audiologist or hearing aid specialist are gathered before authorizing hearing aids. When authorizing hearing aids, the VR counselor also considers the effect of the customer’s hearing on specific training requirements, job requirements, and safety needs. The VR counselor documents the expected outcomes in the case file as part of the assessing and planning process.

The VR counselor develops the individualized plan for employment (IPE) to purchase hearing aids after receiving:

* a medical evaluation, as described below on Form VR3105B, Hearing Evaluation Report: Otological Examination, or medical records from the otologist or otolaryngologist including the medical evaluation, and dated within the last six months;
* an audiological assessment completed by a licensed audiologist or hearing aid specialist:
  + on the Form VR3105C, Hearing Evaluation Report: Audiometric Examination dated within the last six months; or
  + documented on audiological records containing the same audiometric and tympanometry required on Form VR3105C and dated within the last six months; and
* the completed hearing evaluation form with hearing aid recommendations recorded on Form VR3105D, Hearing Evaluation Report: Hearing Aid Recommendations.

It is recommended that a medical evaluation be obtained to rule out any medical reason for the customer’s hearing loss, such as infection, injury or deformity, ear wax in the ear canal, and in rare cases, tumors.

When the customer is 17 years of age or younger, a medical evaluation must be obtained by an otologist or otolaryngologist. Refer to VRSM E-200: Summary Table of Approvals, Consultations, and Notifications.

Medical evaluation:

* for seasoned hearing aid users (not a first-time hearing aid user) with no medical issues (for example, no sudden hearing loss or extreme changes in hearing loss), it is best practice to obtain a medical evaluation. The medical evaluation is completed by a physician or physician assistant or nurse practitioner who is supervised by a licensed physician. When a medical evaluation is not completed for a seasoned hearing aid user with no medical issues, the VR Supervisor (VRS) may waive the requirement for medical evaluation.  This waiver is entered in RHW as an Approval Request and Approval Response case note with the Add to Topic of “Waiver of Medical Evaluation for Seasoned Hearing Aid User”.
* for a first-time hearing aid user, a medical evaluation is required from an otologist or otolaryngologist. If the staff member is experiencing substantial delays in securing the evaluation by the otologist or otolaryngologist, the medical evaluation may be performed by the customer's PCP or if the customer does not have a PCP, the physician who performs the office's general medical evaluations may conduct the medical evaluation.

When the VR counselor receives a recommendation for a complete-in-canal (CIC) hearing aid, he or she ensures that the audiologist sufficiently justifies the added benefits of a CIC hearing aid when compared to an alternative style with the same capabilities.

It is advised that the VR counselor consult with a Texas Health and Human Services Commission (HHSC) [Deaf and Hard of Hearing technology specialist](https://hhs.texas.gov/services/disability/deaf-hard-hearing#resource-specialist)when considering the purchase of additional non-contracted technology recommended by the dispenser.

For information on purchasing hearing aids, refer to VRSM D-209-3: Contracted Goods and Services and VRSM D-210: Exceptions to Contracted Fees and MAPS Fees.

When an audiologist or hearing-instrument specialist provides a vocational justification that warrants an aid without a manual telecoil, it is recommended that the VR counselor consult with a local deaf and hard of hearing technology specialist before purchasing the aid. The VR counselor may request a workplace or environmental assessment completed by the deaf and hard of hearing technology specialist to identify additional technology needs.

#### Staff Qualifications for Hearing Aid Dispensers

Individuals who provide and bill for services associated with the purchase of hearing aids and related accessories must meet the qualifications and licensing requirements of the [Texas Department of Licensing & Regulation](https://www.tdlr.texas.gov/), which is the designated regulatory authority for audiologists and hearing aid specialists (hearing aid dispensers).

|  |  |  |
| --- | --- | --- |
| **Job Title** | **Job Function** | **Required Qualifications** |
| Audiologist | * Provides audiological examinations * May dispense hearing aids * May provide basic audiometric assessments * May provide hearing aid evaluations | Must comply with all provisions of:  Texas Administrative Code Title 16, Part 4, Texas Department of Licensing and Regulation, Chapter 111, Speech-Language Pathologists and Audiologists |
| Hearing aid specialist | * Dispenses hearing aids * May provide basic audiometric assessments (MAPS 92551–92559) * May provide hearing aid evaluations | Must comply with all provisions of:  Texas Administrative Code, Title 16, Economic Regulation, Part 4, Texas Department of Licensing and Regulation Chapter 12, Hearing Instrument Fitters and Dispensers |

#### Comparable Benefits

Use of comparable services and benefits is not required for rehabilitation technology, including hearing aids.

#### Customer Participation in Cost of Services

Customers may be required to participate in the cost of services. For more information on applying basic living requirements (BLR) to contracted hearing aids and accessories, refer to VRSM D-203-4: Customer Participation in the Cost of Services.

#### Hearing Aid Recommendations

The selected provider must complete Form VR3105D, Hearing Evaluation Report: Hearing Aid Recommendations, indicating the:

* brand name and model number (not serial number);
* type of hearing aid, such as:
  + behind-the-ear;
  + in-the-ear;
  + in-the-canal;
  + complete-in-canal; or
  + bilateral contralateral routing of signal;
* color selection;
* receiver information;
* earmold information;
* quantity of hearing aids;
* cost of hearing aids; and
* any required justifications.

#### Service Charge to the Hearing Aid Dispenser

The service charge is the dispenser's usual and customary charge, not to exceed the Maximum Affordable Payment Schedule (MAPS), for:

* initial fitting, including activation of a telecoil;
* up to four follow-up visits without any time limitations for adjustments, including:
  + post-fitting evaluation; and
  + report of hearing aid performance and customer level of satisfaction; and
* instructions on the care and use of the instrument;
* the warranty including the warranty end date; and
* provided the customer with the manufacturer's User Instructional Brochure.

#### Service Charge for Replacement Hearing Aids

For hearing aids replaced under the three-year warranty, use MAPS code 00076 if the dispenser requires payment of a service charge. If the service charge for a replacement hearing aid or aids is paid, four additional follow-up visits are included in the cost of the service. These are in addition to unused visits from the original service charge.

#### MAPS Codes for Hearing Aid Service Charges

* 00075 - Unspecified service charge. Rate to be determined by PRS/CO Programs
* 00076 - Service Charge for Hearing Aid $0 - $1000 Manufacturer’s Lowest List Price
* 00077 - Service Charge for Hearing Aid $1001-$1500 Manufacturer’s Lowest List Price
* 00078 - Service Charge for Hearing Aid $1500+ Manufacturer’s Lowest List Price

The hearing aid dispenser must complete the Initial Fitting Acknowledgements section on the Form VR3105E and submit the report to TWC-VR immediately upon receipt of the customer’s signature indicating receipt of the hearing aids. The hearing aid dispenser must schedule an appointment with the customer to return for post-fitting no later than 14 days after the date the customer received the hearing aids. If the customer does not attend an appointment with the dispenser within 14 days of receiving the hearing aids, the dispenser must notify VR staff that the customer has not returned for the post-fitting appointment. If the customer does not keep the post-fitting appointment, VR staff contacts the customer before the 30-day trial period ends to verify that the customer has received and is satisfied with the hearing aids. When the hearing aids are returned within the 30-day trial period, the original service charge covers any services for the replacement hearing aids.

#### Earmolds and Canal Impressions

Earmolds and canal impressions may be:

* required for hearing aid purchases;
* purchased from the contracted hearing aid manufacturer, audiologist, or hearing aid dispenser;
* paid for separately (not to exceed MAPS); and
* purchased for diagnostic purposes.

Custom-made ear plugs, which look like earmolds and are made for sound protection, may be purchased to preserve the customer's residual hearing while performing work duties.

#### Binaural

Binaural aids may be purchased when:

* recommended by the audiologist or hearing aid service provider; and
* a documented vocational benefit exists.

#### Hearing Accessories

An audiologist or hearing aid dispenser may recommend certain accessories and devices that work with the hearing aids to enhance the customer's ability to hear and understand conversational speech and environmental sounds. One example is a device that streams sounds from the telephone, television, and music player, as well as a compatible microphone, directly to the hearing aids. These may be purchased when the VR counselor determines that any of the recommended accessories are vocationally relevant, as such accessories must be vocationally necessary and not used solely for personal purposes.

Another accessory that may be purchased is a hearing aid drying kit, which draws moisture from the hearing aids to prolong their life span. The audiologist or dispenser is not required to recommend the kit for VR staff to purchase this accessory.

#### MAPS Codes for Contracted Hearing Aids, Earmolds, and Accessories

|  |  |
| --- | --- |
| Beltone | BELTO |
| Oticon | OTICO |
| Phonak | PHONA |
| GN Resound | GNRES |
| Siemens/Signia | SIEME |
| Sonic Innovations | SONIC |
| Starkey | STARK |
| Unitron | UNITR |
| Widex | WIDEX |

#### Repair

Payment for repair of a hearing aid, including labor and shipping and handling charges, must not exceed the cost of a new hearing aid.

#### Frequency Modulation System

The VR counselor may purchase a frequency modulation (FM) system directly from a manufacturer or an audiologist. However, the VR counselor may not pay a service fee, including any fitting and dispensing fees, when he or she purchases an FM system through an audiologist.

When additional training is needed for an FM system not purchased from the hearing aid manufacturer at the time of purchasing the hearing aids, the VR counselor contacts the deaf and hard of hearing technology specialist to request training for the customer on the use of the device and to perform troubleshooting of any issues with the device. Services provided by the deaf and hard of hearing technology specialist are free and may be used when available. If the required training is not available from the deaf and hard of hearing technology specialist, the VR counselor may negotiate payment with the provider for training the customer on the use of the device and for solving problems that arise with the device.

#### Process and Procedure

When the VR counselor receives, reviews, and approves a completed Form VR3105D, Hearing Evaluation Report: Hearing Aid Recommendations, two service authorizations (SA) are issued and submitted:

* one to the contracted hearing aid manufacturer for the purchase of the hearing aid(s) and any accessories, with delivery instructions indicating the name, account number, and address of the dispenser where the items are to be shipped with the completed VR3105D; and
* one to the hearing aid dispenser for related service fees and any accessories.

VR staff then submits the VR SA for the hearing aid and any accessories with the completed VR3105D the contracted hearing aid manufacturer for fulfillment. The contracted hearing aid manufacturer ships the hearing aid or aids and any accessories to the hearing aid dispenser for dispensing.

VR staff prints a copy of the hearing aid SA to a PDF file and notes on the SA “courtesy copy” and submits a copy of the SA to the hearing aid dispenser. Once the hearing aid dispenser receives the courtesy copy of the hearing aid SA, the dispenser:

* reviews the details on the courtesy copy SA; and
* notifies the VR staff of any discrepancies between the SAs in need of correction.

If a corrected SA is required, VR staff must provide:

* an updated SA to the hearing aid manufacturer; and

an updated courtesy copy to the dispenser.

The courtesy copy of the SA sent to the hearing aid dispenser also notifies the dispenser to send ear impressions for ear molds, if appropriate. Any changes made to the SA submitted to the hearing aid manufacturer must be documented in RHW and the updated SA must be resubmitted to the hearing aid manufacturer.

#### Payment for Hearing Aids to the Manufacturer

Upon receipt of an invoice, VR pays the contracted hearing aid manufacturer for the hearing aid and/or accessories when the invoice complies with requirements below:

* VR-SFP Chapter 3: Basic Standards;
* VR-SFP Chapter 6: Hearing Aids and Related Accessories;
* VRSM D-208-2: Elements of an Invoice; and
* verification by VR staff with the dispenser that the hearing aids and accessories have been received with a detailed case note entered in RHW; or
* receipt of a Form VR3105E, Hearing Aid Fitting and Post-Fitting Report with the Initial Fitting Acknowledgements section completed and signed by the customer.

#### Payment for Hearing Aids Service Charges to the Dispenser

For the hearing aid dispenser to receive payment for services provided, the hearing aid dispenser must submit the following:

* A completed Form VR3105E, Hearing Aid Fitting and Post-Fitting Report, indicating the customer has received the hearing aids and is satisfied with the hearing aids and any accessories, as indicated by the customer signing and dating the form;
* Post-fitting documentation such as:
  + an audiogram of functional results for each ear (aided); or
  + measurements for each ear (aided); and
* An invoice that complies with VRSM D-208-2: Elements of an Invoice.

If the customer fails to attend the scheduled post-fitting appointment, the dispenser may be paid the service charge once the:

* field staff documents at least three attempts to contact the customer about attending the post-fitting appointment; and
* the VR counselor enters a purchasing case note that justifies payment of the service charge without the customer's attendance at the post-fitting appointment.

#### Warranty

Hearing aids purchased from contracted hearing aid manufacturers have a three-year Loss/Damage warranty with No Cost for replacement. The customer should contact the VR counselor or staff to report issues with the hearing aid(s). When hearing aid(s) need to be replaced under the warranty, the audiologist, hearing aid specialist, and/or VR staff must complete Form VR3105G, Hearing Aid & Accessories Loss/Damage Replacement Request. If the form is completed by the audiologist or hearing aid specialist, the completed form is immediately sent to the field staff who ordered the services for the customer. Field staff will then submit the completed form to the manufacturer. The manufacturer will ship the replacement hearing aid(s) to the audiologist or hearing aid specialist listed on Form VR3105G and notify TWC VR staff of the shipment.

If the TWC case has been closed and/or there are no remaining visits for the original service charge, a new service charge for replacement hearing aid(s) may be paid to the audiologist or hearing aid specialist.

#### Returns

The hearing aid dispenser that dispensed the goods or equipment to the customer must provide written notice to the VR office that issued the SA when any goods or equipment purchased with VR funds are returned to the manufacturer for any reason. The hearing aid dispenser completes the Form VR3105F Hearing Aid and Hearing Aid Accessories Return and submits the completed form to the manufacturer with the returned items.  The dispenser submits the completed form to the VR office immediately upon return of the items.

The Form VR3105F Hearing Aid and Hearing Aid Accessories Return form must include:

* the customer's name;
* the case identification number;
* SA number associated with the returned items;
* a description of the item returned;
* the reason for the return;
* the amount of credit due to VR; and
* the date and method that the item was returned including the bill of lading or shipment number from the carrier.

### C-704-11: Cochlear Implant and Bone Anchored Hearing Aid Processor Replacement, including BAHA with headband or softband

The VR counselor may authorize replacement of cochlear implant and bone anchored hearing aid (BAHA) processors, including BAHA with headband or softband when they are expected to improve the customer's ability to participate in employment and/or training that is required for a specific employment outcome identified on the IPE. As part of the assessing and planning process, the VR counselor documents the expected outcomes, such as the expectation of an improved ability to understand spoken communication or respond to environmental cues.

TWC must use comparable benefits, when possible, when planning services related to hearing aids, cochlear implants, and BAHA, including BAHA with headband or softband for customers ages 18 and younger. To this extent, TWC may pay for any deductible, co-payments, and/or coinsurance for the provision of these goods and services if the total cost (insurance paid amount plus VR funds paid toward cost) does not exceed allowable VR contract rates.

Replacement of processors may not be authorized solely for the sake of upgrading to newer technology.

VR is the payer of last resort.

VRSM B-310-5 Comparable benefits and required VRSM B-310-6 Customer Participation in Cost of Services must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in D-203-2: Best Value Purchasing.

With respect to VR's responsibility for payment, after the customer's primary and/or secondary benefit coverage has been applied and customer's ability to pay has been determined, VR may pay to the provider an amount equal to the customer's co-payment, coinsurance or deductible due. VR payment does not exceed the insurance allowed amount or the allowable VR rate or VR contract rate, whichever is less.

Careful consideration of the following must take place when assessing the need for such replacement:

* The customer's vocational goal, including tasks, functions, and work conditions, particularly where it relates to the customer's ability to hear and understand conversational speech and/or environmental sounds
* The potential impact on the customer's ability to obtain and maintain employment if replacement is not made
* The availability of assistive technology to enable the customer to gain full benefits in training or on the job
* The status of the customer's device, especially relating to:
  + warranty coverage;
  + physical condition; and
  + need for repair, if any.

The evaluation report completed by the audiologist and otologist must include:

* the diagnosis;
* recommendations for treatment, including a letter of medical necessity; and
* anticipated prognosis.

A courtesy packet is sent to the following for consultation before planning the purchase of any replacement processor:

* the VR program specialist for the deaf and hard of hearing (for all caseloads except Blind and Visual Impairment (BVI) caseloads); or
* the state office manager for blind services field support (for BVI caseloads).

The courtesy case packet includes the:

* medical, audiological, speech, and language evaluations and reports as specified above; and
* justification of how device replacement will lessen the vocational impediment.

Refer to the checklist on the Deaf and Hard of Hearing intranet page for items to be included in the courtesy packet.

After the VR program specialist for the deaf and hard of hearing or the state office manager for blind services field support reviews the courtesy packet, a case note documenting the consultation is entered in RHW.

VR Manager approval is required for cochlear implant and bone-anchored hearing aid processor replacement, including BAHA with headband or softband.

The cost of the recommended replacement processor may exceed the threshold set in MAPS. When this occurs, medical director consultation is required to override the pre-set rate in MAPS. To obtain medical director consultation, the VR counselor sends an email to [VR Medical Services](mailto:mailtovr.medicalservices@twc.texas.gov) along with the:

* evaluation report from the audiologist;
* manufacturer's quote for processor replacement; and
* VR justification for the upgrade.

All medical services related to replacement of processors are performed by otologists and licensed audiologists.

## C-705: Employment Supports for Brain Injury Overview

Employment Supports for Brain Injury (ESBI) services benefit individuals with acquired brain injuries by encouraging the development of community-based Interdisciplinary Teams (IDTs) throughout Texas. The purpose of this program is to enhance employment outcomes for individuals with brain injuries.

ESBI services are provided to integrate the therapy and employment needs of Vocational Rehabilitation (VR) customers experiencing persistent functional limitations resulting from an acquired brain injury. ESBI is employment-focused. Services can involve the coordination of multiple providers to assist VR customers in maintaining or achieving a competitive integrated employment outcome. ESBI addresses deficits in functional and cognitive skills based on individually assessed need. All customers do not need all services. Services include an array of available therapeutic, employment, and community reintegration support to assist the customer in reaching successful employment outcomes.

ESBI services may be provided in a nonresidential or residential setting. Generally, the VR counselor should expect a customer needing ESBI services to require a coordinated multiservice approach to address cognitive issues and other comorbidities. The IDT's therapeutic intervention occurs during the three employment-based phases of ESBI:

* Initial Assessments and Evaluations
* Therapeutic Interventions
* Employment Services

For more information and maximum session limits, refer to VR Standards for Providers (VR-SFP) 21.5 Employment Supports for Brain Injury Services.

### C-705-1: Referrals from Employment Supports for Brain Injury Providers

ESBI referrals may come from several different entities during different stages of an individual's rehabilitation process. Referrals may come from a ESBI provider. Referrals from a provider are not a guarantee that the provider will be selected to work with the referred individual. The selection is based on the customer's employment needs and informed customer choice. See VR-SFP 3.2.6 Referrals to VR by a Provider for more information.

### C-705-2: Evaluation for Employment Supports for Brain Injury Referral

Before referring a customer to a ESBI provider, the VR counselor must determine whether the customer is ready to participate in services designed to prepare for, obtain, maintain, and advance in competitive integrated employment. Once an application is completed, the VR counselor must verify the diagnosis of a brain injury and the medical stability of the condition by reviewing existing records, including a recent neuropsychological evaluation. After reviewing existing records, the VR counselor orders any additional assessments necessary to make the eligibility determination.

Vocational evaluation and environmental work assessments are available tools that VR counselors are encouraged to use in gaining a clear vocational picture of the customer's ability to benefit from services. If there is still not enough evaluative information to make an eligibility decision, the VR counselor and the customer work together to develop a trial work plan. The goal of trial work experiences is to determine if the customer is ready to benefit from services to prepare for employment. See VRSM B-310: Trial Work Services for more information.

If a trial work placement is successful, the VR counselor retains the work-based information as part of future work experiences to be developed to prepare the customer for a successful competitive integrated employment outcome.

Only a VR counselor can make eligibility determinations. The VR counselor can consult with the specialized medical consultant (State Physical Medicine and Rehabilitation (PM&R) consultant or State Neuropsychological consultant, in relation to head injury) by sending the case to the  [VR Medical Services mailbox](http://mailto:vr.medicalservices@twc.texas.gov/) using the checklist provided on the Medical Services intranet page.

The specialized medical consultant provides an independent assessment of the collected records to assist the VR counselor in determining if diagnostics are complete and if they show that available VR services will correct or substantially modify a stable or slowly progressive physical or mental impairment, one that constitutes a substantial impediment to employment. The specialized medical consultant may also offer recommendations on the level of services needed if the VR counselor determines that the customer is eligible.

### C-705-3: Assessing and Planning for Services

Once eligibility is determined, the VR counselor reviews records and/or orders any other additional assessments necessary to plan for services. In addition to the usual services that are reasonable and necessary to meet a customer's rehabilitation needs, services for a customer with acquired brain injury may also include:

* cognitive rehabilitation (using the Maximum Affordable Payment Schedule (MAPS))—see VRSM C-703-26: Rehabilitative Therapies for information;
* contracted ESBI non-residential services; or
* contracted ESBI residential services.

See VRSM B-400: Completing the Comprehensive Assessment for more information.

While developing the comprehensive assessment in collaboration with the customer to determine the nature and scope of ESBI services that are necessary, initial assessments are obtained from the ESBI residential or nonresidential provider, as authorized by the VR counselor and coordinated by the ESBI designated case manager.

It should be noted that residential ESBI services will only be authorized when:

* access to coordinated nonresidential or outpatient services are not available for a customer who lives in a remote area—that is:
  + local outpatient rehabilitation providers are not available within the customer's community; or
  + attempts to recruit and contract with local providers have not been successful; or
* there are documented therapeutic reasons that the customer cannot progress without certain interventions only available in a residential setting.

The customer must have a confirmed and documented place to live after discharge. Documentation in the case file must confirm that:

* the customer can learn and transfer skills back into a local community employment setting; or
* the interdisciplinary team (IDT) has a plan in place for transferring strategies to the customer's local employment environment upon discharge.

If residential evaluation services are indicated by existing evaluations and assessments, the VR counselor coordinates with the designated medical services coordinator (MSC) and a contracted ESBI residential provider of the customer's choice to schedule admission for planning and evaluation.

Otherwise, the VR counselor works with a contracted ESBI nonresidential provider to refer the customer for the Initial Assessment and Evaluation Plan (IAEP). The IAEP includes a review of existing recent occupational therapy, physical therapy, speech therapy, and/or cognitive evaluations in relation to any existing work experience evaluations, vocational evaluations, and/or environmental work assessments. Assessments that are necessary are conducted as part of the evaluation plan authorized by the VR counselor with input from the ESBI IDT. The IDT's IAEP includes short- and long-term goals, treatment recommendations, and an expected time frame for necessary therapeutic services.

To assist the VR counselor with decisions regarding the customer's progress toward a successful outcome, the evaluations and recommendations of the IDT may be reviewed by the specialized medical consultant before the Interdisciplinary Program Plan (IPP) and the Individualized Plan for Employment (IPE) are completed.

When sending a customer for an IDT IAEP, a courtesy case file is sent to the MSC, along with a completed Form VR5000, Referral for Provider Services to coordinate purchasing for the case and include use of any comparable benefits.

For more information, refer to VRSM 706-3: Coordination of Services Through the Designated Medical Services Coordinator. VR policy requires best value purchasing and documentation that all comparable benefits have been explored before writing the IPE. Coordination with the MSC must include the investigation and application of available benefits for the customer. For more information, see VRSM D-200: Purchasing Goods and Services.

Any use of pharmaceutical drugs (chemical restraint) to control inappropriate behavior must be stabilized before an individual may receive ESBI services. The IDT must meet and have a plan for a customer's behavioral issues as part of the IPP and consider whether the customer is able to benefit from other services being provided. If the IDT determines that the customer is not likely to benefit from other services, the customer is discharged until stabilization is achieved. The physician and the IDT must monitor chemical restraint programs closely for desired responses and adverse consequences.

If services from a residential ESBI provider are required, a maximum of four months can be added to the IPE, but only if the documented criteria are met and intermediary goals are set for measurable and observable progress toward the employment goal. Customers who do not demonstrate progress toward intermediary goals may be discharged, and alternative interventions may be considered to meet customer goals. Additional residential services beyond four months must have VR Supervisor approval in 30-day increments. Managerial oversight must not cause breaks in service for customers who demonstrate progress toward goal achievement. Decisions made by the VR counselor and the VR Supervisor, when necessary, are made in a timely fashion in accordance with the IPP.

The following items must be included in the IPE for ESBI services:

* Employment goal
* Short- and long-term (intermediate) employment goals
* Comparable benefits
* Types of therapeutic interventions
* Frequency and length of treatment
* Specific employment providers
* Specific ESBI provider
* Ancillary services (as necessary)
* Customer responsibilities

The IPE must be reviewed and amended when significant changes are identified in the IPP or when additional services are approved. For more information on developing the IPE, see VRSM B-500: Individualized Plan for Employment and Post Employment.

#### Required Attendance and Documentation

When customers participate in ESBI services, the VR counselor is a critical part of the IDT. The VR counselor advocates for the customer. As an advocate, the VR counselor is empowered to ask questions and ensure the customer is receiving the agreed-upon services. Extensive interaction with the IDT, the customer, and his or her support system is necessary to ensure that the customer is progressing in an effective and efficient way toward the customer's ultimate employment goals.

The VR counselor must ensure that the customer is benefiting from treatment. If the customer is participating in ESBI services, the VR counselor is a member of the IDT and must follow the customer's progress through treatment-related team meetings. It is essential that the VR counselor evaluate the customer's progress through regular contact with the IDT, the customer, and the customer's support system, and by reviewing the documentation submitted on a weekly basis.

When a rehabilitation treatment does not lead to progress toward the work-based goals identified in the IPP, the VR counselor must work with other members of the IDT to consider appropriate modifications to the plan. When the VR counselor identifies that the customer is not making progress and no other intervention is available to modify the condition in a reasonable time, the VR counselor may discontinue sponsorship of the treatment and consider other approaches to employment or referral to independent living services to maximize the customer's abilities in the home and community.

The VR counselor must:

* attend monthly IDT meetings;
* document in ReHabWorks (RHW):
  + progress toward rehabilitation goals;
  + progress toward employment goals; and
  + any VR counselor–approved modifications to the IPP; and
* obtain a copy of the monthly IDT meeting report and file it in the customer's paper case file.

See VR-SFP 21.5.4 Individual Program Plan Service Definition.

### C-705-4: Coordination of Employment Supports for Brain Injury

When referring a customer to ESBI, the VR counselor receives unit-purchasing-specialist (UPS) assistance by sending a packet to the MSC. The MSC coordinates:

* the evaluation of purchasing and billing from the ESBI providers; and
* contracted ESBI nonresidential services or contracted ESBI residential services.

The MSC must issue all service authorizations for all contracted ESBI therapeutic residential and nonresidential services, and the UPS coordinates ESBI-related employment services authorizations in a residential or nonresidential setting.

Upon receiving a courtesy case file, and after coordination with the UPS, the MSC:

* reviews referral information and discusses with the VR counselor any problems encountered, additional medical information needed, or related medical questions;
* confirms the availability of comparable services and benefits;
* informs the VR counselor of the estimated costs for medical services before encumbering funds;
* discusses with the provider or the provider's staff members the payment allowances for related medical services;
* coordinates ESBI services;
* issues ESBI service authorizations, except for those covered by the employment services contract;
* communicates with the customer, the VR counselor, and providers about ongoing services;
* notifies the VR counselor, service provider, and the customer, if necessary, about the date, time, and location of scheduled services;
* provides the VR counselor with documentation of significant events in the medical services process;
* requests approval from the VR counselor to process claims for payment after deducting other payments;
* processes documents on encumbrances for medical services;
* maintains effective working relationships with ESBI program staff members and the medical community; and
* serves as a resource to ESBI program staff members in field offices when coordinating medical services for the customer.

The MSC or the medical services technician (MST) must issue all service authorizations for contracted ESBI services provided in a residential or nonresidential setting. The UPS coordinates the service authorizations for all ESBI employment services.

The MSC coordinates contracted nonresidential or residential ESBI services for eligible VR customers. The MSC or MST contacts the ESBI provider to:

* verify receipt of required physician orders for nonresidential or residential services and verify that the provider has completed an assessment confirming that the customer is appropriate for provider services;
* verify comparable benefits, if applicable, with the ESBI provider representative to include the specific benefit coverage for ESBI services and the expected customer portion of the cost, and document the information and its source in a contact note;
* verify that ESBI services were approved;
* place documentation of approval in the case file if the comparable benefit requires preauthorization for ESBI services; and
* review Texas Workforce Commission–VR payment policies and limitations and determine whether the customer's medical records must be faxed or mailed to the provider, and if prescriptions must be updated.

#### The Medical Services Coordinator Creates Service Records

Residential ESBI services are paid using a daily contract rate. Nonresidential ESBI services are paid using an hourly rate. The MSC refers to the tiered contract rate for the payment rate and creates service records for all anticipated services, including:

* ESBI facility base services (per standards);
* physician consultations (using MAPS) (routine medical management is included in the daily contract rate; the VR counselor refers to the VR-SFP Manual);
* medications (at cost if purchased from an outside pharmacy—prescription is required);
* individual therapies at an ESBI facility based on the tiered rates; and
* neuropsychological evaluation (using MAPS).

If the facility is also a hospital and has a pharmacy, medications should be purchased through the hospital contract rate.

#### When the Customer Has Verified Comparable Benefits

When the customer has comparable benefits that have been verified, the MSC creates service records using the customer portion not covered by the comparable benefit as the cost for the service. The customer's portion must not exceed the ESBI standards rate or the MAPS rate for the ancillary service, whichever is applicable.

If the customer's comparable benefits have not been verified, the MSC creates service records as if the customer does not have any comparable benefits by following the steps below.

1. The MSC documents the estimated cost in RHW and contacts the VR counselor to:
   * provide an estimate of the total cost for requested service(s) and anticipated ancillary services; and
   * notify the VR counselor to request the availability of funds from the caseload budget.
2. The MSC contacts a ESBI facility representative to:
   * obtain the admission or start date and advise the ESBI facility representative that the service authorization will be sent (services cannot begin until the provider receives the service authorization); and
   * obtain preadmission instructions for the customer.
3. The MSC then documents the contact in a case note.
4. The MSC issues service authorizations and sends a copy of the service authorizations to the ESBI facility and ancillary medical service providers. The MSC and UPS continue to collaborate on other ancillary service requests. The UPS coordinates any nonmedical purchases necessary for the employment goals of the customer. The MSC:
   * reviews the service records to confirm the information is correct and ensure that accurate service authorizations will be generated;
   * issues service authorizations for planned service and all anticipated ancillary services (If comparable benefits are verified, the MSC notes the specific comparable benefit in the Payment or Special Instructions section of the service authorization and requests a copy of the Explanation of Benefits with the invoice for payment. If comparable benefit coverage cannot be established before issuing the service authorization, the MSC notes the reported comparable benefit in the Payment or Special Instructions section of the service authorization and alerts the provider of possible benefit coverage.);
   * ensures that the required approvals are documented in RHW before issuing a service authorization;
   * issues a service authorization for an initial period of 120 days and extends ESBI services in 30-day increments (or shorter increments if fewer than 30 days are needed to complete the program) when VR manager approval is documented and an updated IPP is received; and
   * faxes, e-mails, or mails the service authorizations to the ESBI facility and ancillary service providers, as applicable.

Note: Given the length of the program, service authorizations have multiple line items corresponding to a facility's billing cycle and interim invoice.

1. The VR counselor or rehabilitation assistant contacts the customer to coordinate the admission or start date of ESBI services by:
   * contacting the customer and/or family by phone or letter to notify the customer of the admission or start date or to request that the customer and/or family schedule the admission or start date and notify the MSC;
   * verifying whether the customer has received special instructions from the ESBI facility;
   * notifying the VR counselor of the customer's ESBI admission or start date and of any special instructions from the ESBI provider;
   * sending a letter to the customer and/or family (if needed) with the facility admission or start date and including any additional instructions; and
   * documenting the information in a case note.
2. The MSC contacts the ESBI provider facility representative:
   * within two days after the scheduled admission or start date to confirm that the customer started services;
   * to ensure that the ESBI provider representative knows to contact the MSC and the VR counselor if the customer misses more than one day of ESBI services;
   * to follow up with the ESBI provider to ensure that the treatment plan and monthly staffing progress reports are delivered simultaneously to the VR counselor and the MSC; and
   * before the date of expected discharge, to identify medical needs for the customer, including supplies, durable medical equipment, and medication for the first two weeks if the customer is in a residential ESBI setting.
3. The MSC contacts the VR counselor to:
   * notify the VR counselor when the customer is discharged and of any medical needs that the MSC will coordinate (the MSC obtains approval for encumbrances and documents the approval in a case note);
   * forward any medical records received to the VR counselor;
   * notify the VR counselor and the home MSC, if applicable, when the case will be returned to the home MSC; and
   * discuss any additional case coordination needs with the VR counselor.

#### Duration of Employment Supports for Brain Injury Services

ESBI services are not limited by time elapsed since the traumatic brain injury was acquired.

#### Purchasing Employment Supports for Brain Injury Services

Residential ESBI services may be provided for 120 days and then in 30-day increments with VR Manager approval based on progress toward IPP and IPE goals. Nonresidential services are provided in an outpatient setting with total therapeutic hours not to exceed 20 hours per week over a 12-week period unless approved by the VR counselor specifically on the IPE and IPP. If additional services are needed after 12 weeks, service justification must be documented in the case file or IPE amendment if the case is in employment phase in RHW, along with VR Supervisor approval for extensions in up to 30-day increments.

For more information about ESBI services, see VR-SFP Chapter 21: Employment Supports for Brain Injury (ESBI). ESBI service providers must adhere to all requirements set forth in the chapter.

### C-705-5: Creating a Service Record for Employment Supports for Brain Injury

A service record must be created with the following specifications for ESBI services. See VR-SFP Chapter 21: Employment Supports for Brain Injury.

#### Service Records for Non-Residential ESBI

* Level 1 – Employment Supports for Brain Injury (ESBI)
* Level 2 – Non-Residential ESBI

Choose the appropriate specifications for Level 3 and 4 based on the core service to be provided.

#### Service Records for Residential ESBI

* Level 1 – Employment Supports for Brain Injury (ESBI)
* Level 2 – Residential ESBI

Choose the appropriate specifications for Level 3 and 4 based on the core service to be provided.

#### Service Records for IAEP/IPP Attendance and Premiums

* Level 1 – Employment Supports for Brain Injury (ESBI)
* Level 2 – IAEP/IPP Attendance and Premiums

Choose the appropriate specifications for Level 3 and 4 based on the core service to be provided.