# Vocational Rehabilitation Services Manual C-700: Medical Services

Revised August 24, 2018

## 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.

[Comparable benefits (B-310-5)](https://twc.texas.gov/node/) and required [customer participation in cost of services (B-310-6)](https://twc.texas.gov/node/) 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-203-1: Best Value Purchasing](https://twc.texas.gov/node/).

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 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).

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);
* manager;
* central office program specialist; and
* VR medical director.

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

Medical, dental, and ophthalmological consultants provide support to VR staff throughout the VR process.

For more information about the roles of various consultants, refer to [VRSM A-100: Introduction to Vocational Rehabilitation](https://twc.texas.gov/node/).

#### Medical Director

The following require review and approval by the medical director:

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

VR staff must consult with the VR Manager prior to requesting review and approval by the medical director.

#### State Ophthalmology Consultants

The state ophthalmology consultants are ophthalmologists and retinal specialists and surgeons. Ophthalmological and surgical questions are directed to their attention.

#### 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.

#### Regional Dental Consultant

A regional dental consultant (RDC) is required for all dental services.

#### Local Medical Consultant

The following require review and consultation by an LMC:

* Surgical services with the exception of eye surgeries.
* Procedures requiring local and general anesthesia
* Services, procedures, and programs with special requirements

Eye surgeries with complex procedures may need more consultation, staff may contact State office program specialist for blind services.

#### Limitations on LMC Services

The LMC does not examine or treat VR customers, except when:

* the customer is, or has been, the LMC's patient before becoming a VR customer;
* the LMC is asked to provide ancillary services, such as assisting the principal surgeon, giving emergency treatment, etc.; or
* the LMC is the only, or one of the few, specialists in the immediate area.

Other cases may be referred to the LMC for treatment only when

* there is no apparent conflict of interest, and
* the VR counselor has obtained an approval from the VR Manager.

#### 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 and approvals to the appropriate source for review and approval.
3. All required reviews and approvals are documented in RHW before VR commitment to VR sponsorship of a medical service by its inclusion in the IPE or an IPE amendment.
4. After confirming documentation of all required reviews and approvals, medical services must be included in the customer's IPE or IPE amendment.
5. 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.

For additional information about the customer's medical condition, treatment options, and potential employment impact, consult the [Medical Disability Guidelines (PDF)](http://intra.twc.state.tx.us/intranet/vrs/docs/MDG.pdf).

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.

If the recommendations include VR-sponsored surgeries or invasive medical procedures requiring general and or local anesthesia, VR staff:

1. obtain a completed a [DARS3110, Surgery and Treatment Recommendations](https://twc.texas.gov/forms/DARS3110.doc);
2. has the LMC review the DARS3110;
3. has the LMC complete a [DARS3101, Medical Consultant Review](https://twc.texas.gov/forms/DARS3101.docx), before purchasing 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. documents the outcome of the LMC in a case note in RHW.

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 [DARS3108, Dental Report](https://twc.texas.gov/forms/DARS3108.docx) form before services are approved.

If the provider requests authorization for services that exceed the MAPS rates, the VR counselor must obtain approval from 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.

When needing a state ophthalmology or state optometric consultants review, the VR counselor:

* completes [DARS2351, Request for MAPS Consultation (PDF)](http://intra.twc.state.tx.us/intranet/gl/docs/DARS2351.pdf), that 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 program specialist for physical restoration at [VR Medical Services](mailto:vr.medicalservices@twc.state.tx.us) ([vr.medicalservices@twc.state.tx.us](mailto:vr.medicalservices@twc.state.tx.us));
* ensures that the program support specialist forwards the request to the consultant, coordinates with the consultant regarding any additional information that may be needed, receives the consultant's response, and provides a written response to the originator; 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; and
  + processing payment for the completed service in accordance with all programmatic and purchasing requirements.

Local field office staff coordinates customer medical services that are not provided in a hospital, facility, or medical school. These include medical evaluation and treatment in a physician's office, including surgical and physical restoration procedures, therapy services, durable medical equipment, and prosthetic or orthotic services.

The VR counselor sends a complete courtesy case to the medical services coordinator (MSC). After consultation with the VR counselor, thedesignated 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.

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### 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](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d204) for more information about processing after-the-fact service authorizations.

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### 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 obtains approval from the VR medical director.
* If the medical provider requests payment for travel costs, the VR counselor sends the request to state office program specialist for physical disabilities for consultation and obtains Deputy Regional Director approval before authorizing travel costs.
* 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.

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## C-702: Clinical Settings Policies

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### 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 [DARS3422, Reduced Payment Agreement](https://twc.texas.gov/forms/DARS3422.docx). and the DARS3422 is signed by both the MSC and an authorized hospital representative and a copy is placed in the customers 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 PABI services, 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 notifies the customer of the change in writing and refers the customer to other resources or supports for continued hospitalization.

VR Manager approval of written notification of the change in payment authorization must be provided to:

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

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

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

The following procedures for back or neck pain require review by the LMC and the approval of both the deputy regional director (DRD) and VR 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, including spinal fusions, require review by the LMC and the approval of both the deputy regional director (DRD) and VR medical director.

They may be purchased for a customer who meets the following criteria:

* 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 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 being ruled out;
* 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 and the approval of both the deputy regional director (DRD) and the VR 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 and the approval of both the deputy regional director (DRD) and the VR medical director.

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### 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 10 sessions for the life of the case. Additional sessions require consultation with the VR Manager and state medical director approval.
* 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;
* [DARS3101, Consultant Review](https://twc.texas.gov/forms/DARS3101.docx) (completed by the local medical consultant); and
* [DARS3110, Surgery and Treatment Recommendations](https://twc.texas.gov/forms/DARS3110.doc) (completed by the otologist performing the surgery).

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.

DRD 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.

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### 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 obtain approval for a discogram, the VR counselor:

* obtains written justification for the discogram for the requesting physician;
* consults with the VR Manager; and
* submits the written justification along with the pertinent medical records to the state medical director for review and approval.

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### 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.

Purchase of Irlen lenses requires consultation with the VR Supervisor and approval from the VR state optometric consultant.

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.

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### 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

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.

If 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 VR Manager first;
* University of Texas Southwestern (UTSW) technical review of the letter of specification; and
* State Office Orthotic and Prosthetic Review Committee (OPRC) approval.

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, Purchasing Prostheses](http://intra.twc.state.tx.us/intranet/vrs/html/counselor-desk-reference.html) 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 [DARS3601, Upper Extremity Amputation Checklist](http://intra.twc.state.tx.us/intranet/gl/docs/DARS3601.docx) or the [DARS3602, Lower Extremity Amputation Checklist](http://intra.twc.state.tx.us/intranet/gl/docs/DARS3602.docx) 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 UTSW Technical Review

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

* uses the [UTSW cover sheet](http://intra.twc.state.tx.us/intranet/vrs/docs/UTSW-Cover-Sheet.docx), 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;
* requests a revised letter of specification if the prosthetist agrees with the changes; and
* states the reason in RHW if the UTSW recommendations are not followed.

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 follow-up review is allowed. Questions about the UTSW report should be directed to the program specialist for physical disability.

#### 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](http://intra.twc.state.tx.us/intranet/vrs/docs/OPRC-Cover-Sheet.docx), 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 and have received approval of the state medical director.

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 and approved by the VR 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 approval 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.state.tx.us for](mailto:vr.medicalservices@twc.state.tx.us%20for) 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. The treatment is reviewed by the LMC, and approved by the VR Manager and state medical director.

Exceptions require review by the LMC. Approval by the VR Manager and state medical director is required before VR-sponsored treatment for osteomyelitis is included in a customer's IPE.

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### 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.

[Comparable benefits (B-310-5)](https://twc.texas.gov/node/) and required [customer participation in cost of services (B-310-6)](https://twc.texas.gov/node/) 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-203-1: Best Value Purchasing](https://twc.texas.gov/node/).

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 3 months require a VR Supervisor approval.

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### 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)](http://intra.twc.state.tx.us/intranet/vrs/docs/TipsCreatngMultiDisplinWeghtLosPrgrm.docx). 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, obtain final approval for the bariatric surgery from the VR Manager and state medical director.

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### 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;
* consults with the VR Manager;
* obtains state medical director approval 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)](http://intra.twc.state.tx.us/intranet/vrs/docs/TipsCreatngMultiDisplinWeghtLosPrgrm.docx).

VR Supervisor consultation is required for all weight loss plans and treatments. The LMC must review all weight loss plans. The state medical director must approve all weight-loss treatments before the service begins.

For more information, see 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 [DARS3510, Weight-Loss Progress Report](http://intra.twc.state.tx.us/intranet/gl/docs/DARS3510.doc)); 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 medical services coordinator, 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.

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 and consultation with the state office program specialist for physical disabilities. VR Supervisor approval is required prior to authorizing treatment and the MSC must be notified.

### 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 [B-308-1: Required Assessments and Policies for Selected Conditions](https://twc.texas.gov/vr-services-manual/vrsm-b-300#b308-1).

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-221: Health Care Professionals — Required Qualifications for criteria that apply to inpatient rehabilitation facilities.

### C-703-33: Post-Acute Brain Injury Rehabilitation

Post-Acute Brain Injury (PABI) services are provided as recommended by an interdisciplinary team to address deficits in functional and cognitive skills based on individualized assessed needs. Services may include behavior management, the development of coping skills, and compensatory strategies. These services may be provided in a residential or nonresidential setting.

Services are based on an assessment of the individual's assessed deficits. The goal of PABI services for VR customers is to establish new patterns of cognitive activity as well as compensatory mechanisms to achieve a specific employment outcome.

#### Duration of Post-Acute Brain Injury Services

PABI services are not limited by the time that has passed since the traumatic brain injury (TBI) occurred.

The 180-day limit on post-acute rehabilitation services is measured from the first day of services sponsored. Post-acute rehabilitation services are indicated on the IPE "up to 30 days of service" and may be extended to a maximum of 180 days without an IPE amendment when recommended by the interdisciplinary team.

When a post-acute rehabilitation facility divides its program into two phases and releases the customer for a period before bringing the customer back to complete the program, VR counselor may sponsor both periods of PABI services up to a cumulative total of 180 days.

When considering residential PABI services, the VR counselor must consult with the state office program specialist for physical disabilities. The VR counselor must have approval from the state office program specialist for physical disabilities before including residential PABI as a purchased service on an IPE or IPE amendment.

The MSC or medical services technician (MST) must issue all service authorizations for residential PABI services.

When referring a customer to PABI, the VR counselor sends a packet to the MSC. The procedure for the MSC or MST to coordinate residential or nonresidential PABI services for eligible VR customers is as follows.

#### MSC or MST Contacts the PABI Facility

* The MSC or MST verifies receipt of required physician orders for residential or nonresidential services and verifies that the facility has completed an assessment confirming that the customer is appropriate for facility services.
* The MSC or MST verifies comparable benefits, if applicable, with the PABI facility representative to include the specific benefit coverage for PABI services and the expected customer portion of the cost and documents information and the source of information in a contact note.
* If the comparable benefit requires preauthorization for PABI services, the MSC or MST verifies that the PABI services were approved and places documentation of approval in the case file.
* The MSC or MST reviews TWC-VR payment policies and limitations, and determines whether customer medical records must be faxed or mailed to the facility and prescriptions updated.

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For more information about PABI services, see the [VR Standards for Providers Chapter 21: Standards for Post-acute Brain Injury (PABI) Service Providers](https://twc.texas.gov/standards-manual/vr-sfp-chapter-21). Providers of PABI services must adhere to all details stated in that chapter.

### Post-Acute Brain Injury Service Array

#### Post-Acute Brain Injury Residential Services

A detailed list of post-acute brain injury residential services includes:

|  |  |  |
| --- | --- | --- |
| **Residential Core Services** | **Service Delivery Modality** | **Provider Qualifications** |
| Aquatic Therapy | Individual and Group | LP |
| Art Therapy | Individual and Group | LP |
| Behavior Management | Individual | LP or CP |
| Case Management | Individual | CP |
| Chemical Dependency | Individual and Group | LP |
| Cognitive Rehabilitation Therapy (CRT) | Individual and Group | LP |
| Dietary Nutritional Services | Individual and Group | LP |
| Massage Therapy | Individual | LP |
| Medical Services | Individual | LP |
| Mental Restoration | Individual and Group | LP |
| Music Therapy | Individual and Group | CP |
| Neuropsychiatric Services | Individual and Group | LP |
| Neuropsychological Services | Individual and Group | LP |
| Occupational Therapy | Individual and Group | LP or CP |
| Personal Assistance | Individual and Group | PP |
| Physical Therapy | Individual and Group | LP or CP |
| Recreational Therapy | Individual and Group | CP |
| Room and Board | Individual | Qualifications not stipulated |
| Speech and Language Pathology | Individual and Group | LP or CP |

|  |  |  |
| --- | --- | --- |
| **Residential Ancillary Services** | **Service Delivery Modality** | **Provider Qualifications** |
| Audiology | Individual | LP |
| Durable Medical Equipment and Supplies | Individual | Qualifications not stipulated |
| Family Therapy | Individual and Group | LP |
| Family and/or Caregiver Education and Training | Individual and Group | LP or CP |
| Home Modification | Individual | LP |
| Limited Skilled Nursing | Individual | LP |
| Orthosis/Prosthesis | Individual | LP |
| Over-the-Counter Medications | Individual | Qualifications not stipulated |
| Physical Restoration | Individual | LP |
| Prescription Medications | Individual | LP |
| Rehabilitation Technology | Individual | LP, other professionals |
| Transportation | Individual | Qualifications not stipulated |

#### Post-Acute Brain Injury Nonresidential Services

A detailed list of post-acute brain injury nonresidential services includes:

|  |  |  |
| --- | --- | --- |
| **Nonresidential Core Services** | **Service Delivery Modality** | **Provider Qualifications** |
| Aquatic Therapy | Individual and Group | LP |
| Art Therapy | Individual and Group | LP |
| Behavior Management | Individual | LP or CP |
| Case Management | Individual | CP |
| Chemical Dependency | Individual and Group | LP |
| Cognitive Rehabilitation Therapy (CRT) | Individual and Group | LP |
| Dietary Nutritional Services | Individual and Group | LP |
| Massage Therapy | Individual | LP |
| Mental Restoration | Individual and Group | LP |
| Music Therapy | Individual and Group | CP |
| Neuropsychiatric Services | Individual and Group | LP |
| Neuropsychological Services | Individual and Group | LP |
| Occupational Therapy | Individual and Group | LP or CP |
| Physical Therapy | Individual and Group | LP or CP |
| Recreational Therapy | Individual and Group | CP |
| Speech and Language Pathology | Individual and Group | LP or CP |

|  |  |  |
| --- | --- | --- |
| **Nonresidential Ancillary Services** | **Service Delivery Modality** | **Provider Qualifications** |
| Audiology | Individual | LP |
| Durable Medical Equipment and Supplies | Individual | LP or CP |
| Family Therapy | Individual and Group | LP |
| Family and/or Caregiver Education and Training | Individual and Group | LP or CP |
| Home Modification | Individual | LP |
| Limited Skilled Nursing | Individual | LP |
| Orthosis and Prosthesis | Individual | LP |
| Over-the-Counter Medications | Individual | Qualifications not stipulated |
| Personal Attendant Care | Individual | PP |
| Physical Restoration | Individual | LP |
| Prescription Medications | Individual | LP |
| Rehabilitation Technology | Individual | LP, other professionals |
| Transportation | Individual | Qualifications not stipulated |
| Vision Services | Individual | LP |

### Exceptions to Service Array

Should services be medically necessary for rehabilitation purposes (that is, not for medical emergencies) but are not included as a core or ancillary service, a formal request process must be followed before services may be provided to VR customers.

|  |  |  |
| --- | --- | --- |
| Step | Issue | Notes |
| 1 | The Interdisciplinary Team (IDT) or medical expert identifies a need for a service and/or therapy that is not offered in the service array. | Identification of service and/or therapy needed for rehabilitation purposes is based on the medical assessment. |
| 2 | The IDT or medical expert sends a request for the service to the VR counselor. | The request for service must include supporting medical documentation and assessments to explain the necessity of the service and/or therapy and the proposed billing codes (for example, CPT or HCPCS rates) that will be used for billing purposes.  If additional information is needed for decision making purposes, the VR counselor contacts the facility. |
| 3 | The VR counselor sends an email to his or her chain of command and State Office with the following information:   * Customer name * Customer ID * Customer injury * Recommended therapy * Medical needs * Associated CPT, MAPS, or HCPCS codes | The State Office includes the program specialist for physical disabilities, the program manager, and the administrative assistant.  The chain of command includes the VR Manager or staff acting on behalf of the VR Manager. |
| 4 | The VR counselor and the VR Manager determine whether the service is appropriate and medically necessary. | The VR counselor and the VR Manager consider all information related to the customer to determine whether the service is necessary.  If the service is not appropriate or medically necessary, the service is denied by the VR counselor and manager. The VR counselor communicates this decision to the facility and central office. A case note must be entered to document the reason for denial.  If the service is appropriate and medically necessary, the VR counselor and the manager seek approval from chain of command. |
| 5 | The VR counselor sends a request to review and approve the proposed service to regional management. |  |
| 6 | Regional management reviews the request and determines whether the service is appropriate. | If the service is determined appropriate and medically necessary, an email indicating approval by the manager and regional management is sent to state office requesting final review and approval. If the service is not appropriate or medically necessary, the VR counselor and VR Manager deny the service. The VR counselor communicates this decision to the facility and State Office. |
| 7 | State Office reviews the service and determines whether it is appropriate to provide the service to the customer. | Note: If more information is needed to decide, the VR counselor must obtain the information at the request of State Office. |
| 8 | Upon determining whether the service is approved or not approved, the VR counselor communicates the decision to the facility. | The VR counselor provides answers to questions about the decision. If the facility disagrees with the decision, the appeals process must be implemented. |
| 9 | An approved service requires a completed [DARS3472, Contracted Service Modification](https://twc.texas.gov/forms/DARS3472.docx). | The DARS3472 must be signed by the Regional Director or VR Division Director. |
| 10 | The VR counselor issues a service authorization for services. | All the steps above must be completed before issuing a service authorization. |

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**C-704: Durable Medical Equipment**

**C-704-11: Cochlear Implant and Bone Anchored Hearing Aid Processor Replacement**

The VR counselor may authorize replacement of cochlear implant and bone anchored hearing aid (BAHA) processors 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 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.

[Comparable benefits (B-310-5)](https://twc.texas.gov/node/) and required [customer participation in cost of services (B-310-6)](https://twc.texas.gov/node/) 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-203-1: Best Value Purchasing](https://twc.texas.gov/node/).

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 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 for consultation before planning the surgery. 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.

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.

Deputy division director (DRD) approval is required for cochlear implant and bone anchored hearing aid processor replacement.

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