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

Revised February 1, 2023

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## C-701: Professional Medical Services

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### 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](https://twc.texas.gov/vr-services-manual/vrsm-b-100#b101-7).

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 [C-703: Policies for Services, Procedures, and Programs with Special Requirements](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703) 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 [C-703-36: Eye Surgery and Treatment for Eye Conditions](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-36).

#### 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 (PDF)](https://intra.twc.texas.gov/intranet/vrs/docs/workers-comp-access-mdguidelines.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.

#### 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 [VR3110, Surgery and Treatment Recommendations](https://twc.texas.gov/forms/index.html);
2. have the LMC review the VR3110;
3. have the LMC complete a [VR3101, Consultant Review](https://twc.texas.gov/forms/index.html), 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 [C-703-36: Eye Surgery and Treatment for Eye Conditions](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-36) 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 [VR3101, Consultant Review](https://twc.texas.gov/forms/index.html), 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 [VR2351, Request for MAPS Consultation for Visual Services](http://intra.twc.state.tx.us/intranet/gl/html/vocational_rehab_forms.html), 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).

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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 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 (PDF)](http://intra.twc.state.tx.us/intranet/vrs/docs/medservhndbk-twc.pdf) 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 [VR3110, Surgery and Treatment Recommendations](https://twc.texas.gov/forms/index.html), or [VR3109, Eye Surgery and Treatment Recommendations](https://twc.texas.gov/forms/index.html), 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 (PDF)](http://intra.twc.state.tx.us/intranet/vrs/docs/medservhndbk-twc.pdf) 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 (PDF)](http://intra.twc.state.tx.us/intranet/vrs/docs/medservhndbk-twc.pdf) 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.

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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, 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).

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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 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.

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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

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](https://twc.texas.gov/forms/index.html)), 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, 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 [VR3601, Upper Extremity Amputation Checklist](http://intra.twc.state.tx.us/intranet/gl/html/vocational_rehab_forms.html) or the [VR3602, Lower Extremity Amputation Checklist](http://intra.twc.state.tx.us/intranet/gl/html/vocational_rehab_forms.html) 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; 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](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. 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.

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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, 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](https://twc.texas.gov/vr-services-manual/vrsm-d-200).

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.

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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.

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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 [C-701: Professional Medical Services](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c701).

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 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 [VR3109, Eye Surgery and Treatment Recommendation](https://twc.texas.gov/forms/index.html) 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 [C-701-2: Medical Services Required Review and Approvals Policy](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c701-2).

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 [C-701-2: Medical Services Required Review and Approvals Policy](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c701-2) and [VRSM B-101-7: Consultants](https://twc.texas.gov/vr-services-manual/vrsm-b-100#b101-7).

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 [VR2351, Request for MAPS Consultation for Visual Services](https://intra.twc.texas.gov/intranet/gl/html/vocational_rehab_forms.html). The VR counselor completes the 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](https://twc.texas.gov/files/partners/vrsm-e-200.docx).

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](https://intra.twc.texas.gov/intranet/vrs/cdr/cdr-c2-blind-visual-impairments.docx).

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 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
* [VR3109, Eye Surgery and Treatment Recommendation](https://twc.texas.gov/forms/index.html) form (if completed)
* [VR2006E, Interagency Eye Examination Report](https://twc.texas.gov/forms/index.html) (if completed)

The [Eye Surgery/Treatment Consultant Review checklist](https://intra.twc.texas.gov/intranet/vrs/docs/eye-surgery-consultant-review-checklist.docx) is available 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](https://twc.texas.gov/files/partners/vrsm-e-200.docx) 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 [C-703-24: Prescription Drugs and Medical Supplies](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-24) and [VRSM E-200: Summary Table of Approvals, Consultations, and Notifications](https://twc.texas.gov/files/partners/vrsm-e-200.docx).

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 [C-701-3: Coordinating with the Medical Services Coordinator](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c701-3).

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 [CDR C2: Blind and Visual Impairments](https://intra.twc.texas.gov/intranet/vrs/cdr/cdr-c2-blind-visual-impairments.docx).

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 [VR2351, Request for MAPS Consultation for Visual Services](https://intra.twc.texas.gov/intranet/gl/html/vocational_rehab_forms.html)
* 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.state.tx](mailto:vr.mapsinquiry_blindservices@twc.state.tx) and adds "Vision Therapy Consultation" to the subject line.

For more information on vision therapy, refer to [C-703-26 Rehabilitative Therapies](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-26) and [CDR C2: Blind and Visual Impairments](https://intra.twc.texas.gov/intranet/vrs/cdr/cdr-c2-blind-visual-impairments.docx).

C-704: Durable Medical Equipment

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### 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.

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C-704-10: Hearing Aids

Hearing aids may be authorized 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. 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:

* an audiological assessment completed by a licensed audiologist or hearing-aid specialist:
  + on the [VR3105C, Hearing Evaluation Report: Audiometric Examination](https://twc.texas.gov/vocational-rehabilitation-service-forms); or
  + documented on audiological records containing the same audiometric and tympanometry required on the VR3105C and dated within the last 90 days;
* the completed hearing evaluation form with hearing aid recommendations recorded on the [VR3105D, Hearing Evaluation Report: Hearing Aid Recommendations](https://twc.texas.gov/vocational-rehabilitation-service-forms); and
* medical evaluation as described below on the [VR3105B, Hearing Evaluation Report: Otological Examination](https://twc.texas.gov/vocational-rehabilitation-service-forms), or medical records from the otologist or otolaryngologist including the medical evaluation and dated within the last 90 days.

It is recommended 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, 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 (90 days or more) 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 [D-209-3: Contracted Goods and Services](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d209-3) and [D-210: Exceptions to Contracted Fees and MAPS Fees](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d210).

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.

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/vr-services-manual/vrsm-b-300#b310-5) and required [customer participation in cost of services (B-310-6)](https://twc.texas.gov/vr-services-manual/vrsm-b-300#b310-6) 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](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d203-2).

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.

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.

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:vr.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

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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 [C-703-26: Rehabilitative Therapies](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-26) for information;
* contracted ESBI non-residential services; or
* contracted ESBI residential services.

See [VRSM B-400: Completing the Comprehensive Assessment](https://twc.texas.gov/vr-services-manual/vrsm-b-400) 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 [VR3420, Employment Supports for Brain Injury (ESBI)](https://twc.texas.gov/forms/index.html) referral to coordinate purchasing for the case and include use of any comparable benefits.

For more information, refer to 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 [D-200: Purchasing Goods and Services](https://twc.texas.gov/vr-services-manual/vrsm-d-200).

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 [B-500: Individualized Plan for Employment and Post Employment](https://twc.texas.gov/vr-services-manual/vrsm-b-500).

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](https://twc.texas.gov/standards-manual/vr-sfp-chapter-21#s21-5-4).

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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)](https://twc.texas.gov/standards-manual/vr-sfp-chapter-21). ESBI service providers must adhere to all requirements set forth in the chapter.

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