# Vocational Rehabilitation Services Manual C-700: Medical Services

Revised April 1, 2022

## C-701: Professional Medical Services

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### C-701-2: Medical Services Required Review 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 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; 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.

VR staff must send any required reviews or approvals to the appropriate state ophthalmological or optometric consultant for eye surgeries, treatments, or procedures.

#### State Ophthalmological Consultants

The state ophthalmological consultant is an ophthalmologist. VR staff must direct ophthalmological and surgical questions 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.

#### 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.

#### 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.

#### 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, 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.

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 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)](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 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.

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; 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 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-702-7: Length of Hospital Stay—Required Review

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

* When a customer requires hospitalization beyond the length of time to which VR originally agreed and VR payment will not continue, the VR counselor drafts the written notification and sends it to the VR Manager for approval. The VR counselor sends the approved written notification to: the customer;
* the hospital;
* the attending physicians; and
* all other parties concerned.

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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 the approval from 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
* approval of 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 approval from 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 the approval of 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 State Medical Director approval 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 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;
* [VR3101, Consultant Review](https://twc.texas.gov/forms/index.html) (completed by the local medical consultant); and
* [VR3110, Surgery and Treatment Recommendations](https://twc.texas.gov/forms/index.html) (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.

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

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

* otologists; and
* audiologists.

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

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

Dental treatment may be provided as:

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

Dental treatment outlined above requires:

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

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

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

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

### C-703-10: Discograms

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

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

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

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

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

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

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

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

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

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

Glasses may be purchased if needed to complete diagnostic studies.

Before purchasing contact lenses, the VR counselor:

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

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

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

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

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

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

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

### Low-Vision Provider Base

**Procedure**

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

### Optical and Nonoptical Low-Vision Devices

**Policy**

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

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

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

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

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

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

**The Low-Vision Evaluation**

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

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

The DBS01 evaluation is a combination of:

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

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

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

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

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

### Subsequent Low-Vision Evaluation Visits

**Procedure**

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

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

Examples include the following:

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

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

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

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

**Categories of Optical Devices and Price Ranges**

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

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

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

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

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

Examples of devices include the following:

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

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

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

Examples of these devices include the following:

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

**Spherical and Cylindrical Bifocal Microscopes**

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

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

Examples of these devices include the following:

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

**Telescopic and Other Compound Lens Systems**

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

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

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

Examples of these devices include the following:

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

**Prism Awareness Systems**

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

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

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

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

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

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

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

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

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

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

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

To purchase a FCA, the VR counselor:

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

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

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

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

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

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

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

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

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

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

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

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

[C-703-26: Rehabilitative Therapies, Outpatient Services](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-26) has information about limitations.

**C-703-18: Intercurrent Illness**

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

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

These conditions usually are short-term and do not alter the existing IPE. They may be documented as supplemental services with a service justification case note.

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

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

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

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

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

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

**Medical Devices with Unlisted MAPS**

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

See [VRSM D-200: Purchasing Goods and Services, D-210: Medical and Psychological Services (MAPS)](https://twc.texas.gov/vr-services-manual/vrsm-d-200).

**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 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 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 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.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; orthe osteomyelitis condition occurs as a complication of a VR-sponsored surgery.

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

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

**C-703-23: Pain Treatment**

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

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

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

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

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

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

If eye surgery and/or treatment prescription coverage exceeds a three-month time frame, see [C-703-36: Eye Surgery and Treatment for Eye Conditions](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-36) for more guidance.

[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).

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

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

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

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

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

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

VR does not pay for medical services related to pregnancy.

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

**C-703-26: Rehabilitative Therapies**

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

To purchase a rehabilitative therapy, the VR counselor:

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

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

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

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

**Outpatient Services**

Outpatient services may include:

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

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

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

**Physical Therapy**

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

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

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

**Occupational Therapy**

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

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

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

**Speech Therapy**

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

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

**Cognitive Therapy**

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

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

**Vision Therapy**

For more information on vision therapy, refer to [C-703-36: Eye Surgery and Treatment for Eye Conditions](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-36).

**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 obtain final approval for the bariatric surgery from the State Medical Director.

**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;
* 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).

All weight loss plans and treatments require LMC review and consultation with the VR Manager. SMD

For more information, see [E-200: Required Approvals and Consultations](http://intra.twc.state.tx.us/intranet/vrs/docs/vrsm-required-approvals-consultations.docx).

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 [VR3510, Weight-Loss Progress Report](http://intra.twc.state.tx.us/intranet/gl/html/vocational_rehab_forms.html)); and
* provide counseling as needed to promote a positive weight-loss outcome.

**C-703-31: Wound Care**

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

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

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

**Fees for Specialized Programs**

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

**Cardiac Rehabilitation Facilities**

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

A cardiac rehabilitation facility must meet the following criteria:

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

**Rehabilitation Hospital Programs Procedure**

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

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

Some programs also offer the following services:

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

These are appropriate prevocational services for many customers with the most significant disabilities (for example, spinal cord injuries). For information on providing these services, see Back Disorders in [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-219: Health Care Professionals — Required Qualifications](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d219) for criteria that apply to inpatient rehabilitation facilities.

**C-703-33: Fractures**

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

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

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

**Considerations in Vocational Rehabilitation**

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

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

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

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

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

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

**Treatment and Management Options**

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

**Complications of Diabetes**

Diabetes can have several complications, including:

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

**Adaptive Diabetes Equipment and Supplies**

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

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

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

The customer can receive training on equipment from:

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

**Services Provided by Diabetes Educators**

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

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

VR counselors must follow the guidance below.

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

Diabetes educators may provide services in evaluation and training:

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

Diabetes educators also provide the following services:

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

See the [VR Standards for Providers Chapter 7: Diabetes Self-Management Education Services](https://twc.texas.gov/standards-manual/vr-sfp-chapter-07) for contract requirements for diabetes educators.

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

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

The approval 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 occurredIf 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 |
| OcularProsthesis 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).

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; 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 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 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 approval requirements, refer to the State Consultant Approval 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 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, approval from the state optometric consultant is required.

The VR counselor must include the following in the approval 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 and adds "Vision Therapy Approval" 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).

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