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

Revised April 1, 2021

## 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.state.tx.us](https://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.state.tx.us; 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-701-8: Payment to Medical Providers

The following conditions apply to payment for professional medical services:

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

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

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

The following procedures for back or neck pain require review by the LMC and the approval of both the VR Manager and the VR medical director:

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

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

Back or neck surgery 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;
* VR Manager approval; 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 and the approval of both the VR Manager and the VR medical director.

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

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

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

Breast reduction surgery requires review by the LMC and the approval of both the VR Manager and the VR 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 ,VR Manager approval, and State Medical Director approval are required before authorizing cardiac catheterization and/or angiography.

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### 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.

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### C-703-10: Discograms

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

* obtains written justification for the discogram for the requesting physician;
* 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.

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### 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 consultation 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).

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

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

* obtains a psychological evaluation and has the report reviewed by the treating physician;
* obtain 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.

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

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

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## C-704: Durable Medical Equipment

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

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

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

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

VR is the payer of last resort.

[Comparable benefits (B-310-5)](https://twc.texas.gov/vr-services-manual/vrsm-b-300#b310-5) and required [customer participation in cost of services (B-310-6)](https://twc.texas.gov/vr-services-manual/vrsm-b-300#b310-6) must be applied before VR funds are expended.

Because VR uses tax revenue for case service expenditures, the division must purchase the least expensive services that meet the customer's vocational needs. For more information, see the requirements in [D-203-2: Best Value Purchasing](https://twc.texas.gov/vr-services-manual/vrsm-d-200#d203-2).

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

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

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

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

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

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

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

The courtesy case packet includes the:

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

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

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

The cost of the recommended replacement processor may exceed the threshold set in MAPS. When this occurs, medical director approval is required to override the pre-set rate in MAPS. To obtain medical director approval, the VR counselor sends an email to VR Medical Services along with the:

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

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

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

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

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

Vocational evaluation and environmental work assessments are available tools that VR counselors are encouraged to use in gaining a clear vocational picture of the customer's ability to benefit from services. If there is still not enough evaluative information to make an eligibility decision, the VR counselor and the customer work together to develop a trial work plan. The goal of trial work experiences is to determine if the customer is ready to benefit from services to prepare for employment. See [VRSM B-310: Trial Work Services](https://twc.texas.gov/vr-services-manual/vrsm-b-300#b310) for more information.

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

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

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

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

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

* cognitive rehabilitation (using the Maximum Affordable Payment Schedule (MAPS))—see [C-703-26: Rehabilitative Therapies](https://twc.texas.gov/vr-services-manual/vrsm-c-700#c703-26) for information;
* contracted ESBI non-residential services; or
* contracted ESBI residential services.

See [VRSM B-400: Completing the Comprehensive Assessment](https://twc.texas.gov/vr-services-manual/vrsm-b-400) for more information.

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

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

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

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

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

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

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

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

When sending a customer for an IDT IAEP, a courtesy case file is sent to the MSC, along with a completed [VR3420, Employment Supports for Brain Injury (ESBI)](https://twc.texas.gov/forms/index.html) referral to coordinate purchasing for the case and include use of any comparable benefits.

For more information, refer to 706-3: Coordination of Services Through the Designated Medical Services Coordinator. VR policy requires best value purchasing and documentation that all comparable benefits have been explored before writing the IPE. Coordination with the MSC must include the investigation and application of available benefits for the customer. For more information, see [D-200: Purchasing Goods and Services](https://twc.texas.gov/vr-services-manual/vrsm-d-200).

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

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

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

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

The IPE must be reviewed and amended when significant changes are identified in the IPP or when additional services are approved. For more information on developing the IPE, see [B-500: Individualized Plan for Employment](https://twc.texas.gov/vr-services-manual/vrsm-b-500).

#### Required Attendance and Documentation

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

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

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

The VR counselor must:

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

See [VR-SFP 21.5.4 Individual Program Plan Service Definition](https://twc.texas.gov/standards-manual/vr-sfp-chapter-21#s21-5-4).

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

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

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

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

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

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

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

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

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

#### The Medical Services Coordinator Creates Service Records

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

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

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

#### When the Customer Has Verified Comparable Benefits

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

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

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

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

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

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

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

#### Purchasing Employment Supports for Brain Injury Services

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

For more information about ESBI services, see [VR-SFP Chapter 21: Employment Supports for Brain Injury (ESBI)](https://twc.texas.gov/standards-manual/vr-sfp-chapter-21). ESBI service providers must adhere to all requirements set forth in the chapter.

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