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CHAPTER 11 – PHYSICAL AND MENTAL RESTORATION

Federal Regulations

34 CFR 361.5 - Definitions
34 CFR 361.48 - Scope of vocational rehabilitation services for individuals with disabilities

State Rule

5 CSR 20-500

1100 PHYSICAL AND MENTAL RESTORATION SERVICES

The following guidance applies to all physical and mental restoration services.

1100.1 Guidance and Definitions

- Physical and mental restoration services means—
  - Corrective surgery or therapeutic treatment that is likely, within a reasonable period of time, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment;
  - Diagnosis of and treatment for mental or emotional disorders by qualified personnel in accordance with State licensure laws;
  - Dentistry;
  - Nursing services;

- Necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;
- Drugs and supplies;
- Prescription of prosthetics and/or orthotics related to the individual's diagnosed disability and is necessary for the achievement of the employment outcome;
- Prescription of eyeglasses and visual services, including visual training, related to the individual's diagnosed disability and necessary for the achievement of the employment outcome;
- Podiatry;
- Physical therapy;
- Occupational therapy;
- Speech or hearing therapy;
- Mental health services;
- Treatment of either acute or chronic medical complications and emergencies that are associated with or arise out of the provision of physical and mental restoration services, or that are inherent in the condition under treatment;
- Special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and
- Other medical or medically related rehabilitation services.

- VR is not a primary insurance or health care provider. Co-pays and deductibles are considered client contributions and are the responsibility of the client. Therefore, the above services should only be authorized after the counselor has:
  - made a thorough search for all comparable services/benefits to include Medicare and/or Medicaid, or private insurance and
  - utilized all available existing medical record information

- Medical/psychological diagnostic services:
  - are not based on financial need.
  - search for and apply all comparable services/benefits, including Medicare/Medicaid, or private insurance.

- may be provided at any stage of the rehabilitation process if required for a more thorough understanding of the client's capacities and limitations in regard to an employment outcome.

- Non-diagnostic medical services are based upon the determination of financial need.

- If multiple bids are required, document the bids in the case file prior to providing the service.

- Extreme medical risk -
  - a probability of substantially increasing functional impairment or death if medical services, including mental health services, are not provided expeditiously
  - must be based upon medical evidence provided by an appropriate licensed medical professional
  - comparable services and benefits need not be determined if it would delay services to the client

- Disability corrected –
  - a client whose disability/impairment is corrected by the physical restoration service, to the extent that there are no substantial limitations,
  - are not eligible to receive any other services except guidance and counseling, placement and follow-up, even if they refuse the corrective physical restoration service.

- Inter-current illness –
  - an illness that occurs which requires physical or mental restoration services while the client is participating in a training program.
  - if the training program is outside the State of Missouri, contact the VR agency in the state where the client is participating in training to get their established payment rates for any required physical restoration procedure(s).

1100.2 General Procedures

- Follow guidance provided in CSG Section 500.
- Discuss financial guidelines, collect required financial documentation, and complete Financial Needs Assessment and Cost Scenario when appropriate
- Obtain price quotes (if appropriate) and place documentation in the case folder.
- Prior to the authorization of services, review IPE and "Physical Restoration Services" responsibilities addendum with client and secure client's signature.
- Obtain approval from District Supervisor or Assistant Supervisor as appropriate
- Send a copy of the IPE/responsibilities addendum to the client and a copy of the authorizations to the client and vendor.
- Contact the client immediately after the receipt of services to ensure client satisfaction with the services provided.
- Follow up with the client to monitor satisfactory progress, in accordance with the timelines stipulated in the IPE and document.

1100.3 Authorizations and Billing

- Follow guidance provided in CSG Section 700.
- Medicare and other comparable service participation
    - If VR maximums exceed Medicare rates, Vocational Rehabilitation funds may be used to pay the difference between the client's Medicare benefits and the agency maximum.
    - The combined benefits of any comparable service (private insurance, Medicare, etc.) and the agency contribution should not exceed the agency established maximum for the specific service.

- Medicaid Participation
  - If the vendor accepts Medicaid, then Medicaid payment must be accepted as payment in full. VR does not supplement Medicaid.
  - If the vendor will not accept Medicaid, an authorization for services may be issued.
  - If the client has Medicaid, but Medicaid will not cover the services needed, an authorization may be issued.
- Medical services must be authorized in accordance with either the vendor's usual and customary fees or the "maximum allowable" listed in the VR Procedure Codes, whichever is less**.** No additional funds can be collected from the client.

1110 RADIOLOGY, PATHOLOGY AND LABORATORY

1110.1 Guidance

- In most situations, the counselor will provide radiology, pathology, or other laboratory services in association with other physical restoration services such as surgery or hospitalization.
- When radiology, pathology, or laboratory services are being considered as a diagnostic service:
  - Obtain approval from District Supervisor or Assistant District Supervisor.

1110.2 Authorization and Billing

- Follow guidance provided in CSG Section 700.
- Administration and Interpretation by Same Vendor - The VR maximum allowable cost applies when services are performed and interpreted in a physician's office, clinic, or outpatient department of a hospital, in accordance with the VR Procedure Codes.
- Administration and Interpretation by Different Vendors - If services are performed by one party and interpreted by someone else, the following applies:

- Administration Only - When the vendor performs the administration, but does not interpret, use the appropriate fee number from the VR Procedure Codes.

- Interpretation Only - When the vendor performs the interpretation only, use the appropriate fee number from the VR Procedure Codes.

- Laboratory and Radiology Interpretive Charges – The amount authorized is estimated. Services ordered by the referring physician will be allowed if a report is received. VR will pay the usual and customary fee or agency maximum, whichever is less, in accordance with the VR Procedure Codes.
  - Interpretation at a hospital when the amount is unknown, use Procedure Code 99999982.

  - Laboratory Interpretation - When authorizing laboratory interpretation at a hospital when the amount is unknown, use Procedure Code 99999983.

1120 SURGERY, ANESTHESIA AND DRUGS/SUPPLIES

1120.1 Guidance

- Surgery and treatment may include:
  - medical, surgical and psychiatric treatment provided by general practitioners, specialists, surgeons, assistant surgeons and psychiatrists for home, office or hospital visits;

  - the cost of drugs and supplies incidental to treatment;

  - the cost of surgery for pre and post-operative care;

  - physical or occupational therapy;

  - speech and hearing therapy which is medically directed

- Surgery and treatment, surgical fees, and anesthesia may be provided to clients upon recommendation from a physician or specialist in accordance with VR surgical procedure guidelines.

- Pharmaceutical drugs and supplies associated with the treatment of certain diseases, surgery, or medical procedures, may be provided if they contribute to the client's rehabilitation, and are in accordance with the following conditions:
  - Economic need must be established, except in rare situations when they are used for diagnosis
  - The client is given a prescription from the attending physician
  - There is a specified time period for the provision of drugs/supplies (should not exceed six months)

1120.2 Procedure

- Counselor receives physician's recommendation for surgery/hospitalization (Surgical Report) and acquires the information needed to authorize surgery/hospitalization, including the diagnosis and estimated length of stay.
- Counselor presents the case to the District Supervisor or Assistant District Supervisor for review and approval.

1120.3 Authorization and Billing

- Follow guidance provided in CSG Section 700.
- Pre-Operative Exam
  - Authorize only if requested by the physician.
  - If the procedure codes to be performed are known, authorize accordingly.
  - If the pre-operative services to be provided are unknown, use the Procedure Code: PreOpExam.
  - When billed, add line items to the authorization for the billed procedures and pay at the established rate for each procedure code.

- Surgical Fees:
  - The case management system contains the established rates for medical services based on Current and Practicing Terminology (CPT).

- Multiple Procedures:
  - Apply the maximum fees allowable for multiple procedures (two or more surgical item numbers performed during the same operative session) listed in the VR Procedure Codes which are determined as follows:

    - 100% (full value) for the first or major procedure
    - 50% for the second procedure
    - 25% for the third procedure
    - 25% for the fourth procedure
    - 25% for the fifth procedure

- Bilateral Procedures: (same item numbers) performed during the same operative session fall into the multiple procedure schedule listed above.

- Assistant Surgeon Fees: Contact Client Services Section.

- Determining Total Anesthesia Units:
  - The total number of units to be authorized is determined by adding the “base value”, (amount for the surgical procedure as found in the VR Procedure Code listing), to the time units (15 minutes = 1 unit) as determined by the surgeon.

  - This total is entered on the authorization as the quantity. For example, the basic value (base unit) for anesthesia of 3.0 and a time value of 7.0 would be entered as a quantity of 10.0. This quantity multiplied by the Procedure Code rate gives the total authorized amount.

- Most surgery and treatment procedures will be authorized in accordance with a specific procedure code for that service listed in the VR Procedure Code listing.
  - Some services (such as drugs/supplies) may not be tied to a specific rate and will require the counselor use Procedure Code 152153900 (Other). This procedure code will allow the district office to enter a description for the service.

1130 HOSPITALIZATION AND CONVALESCENT CARE

1130.1 Inpatient Diagnostic Hospitalization

- If inpatient hospitalization for diagnostic purposes is needed to determine if an individual has a disability which results in limitations and an impediment to employment, request approval from the District Supervisor/Assistant District Supervisor prior to issuing an authorization.

- This can only be provided in Application status.

1130.2 Hospitalization (either inpatient or outpatient)

- In connection with medical or surgical treatment, hospitalization may be authorized once the physician/specialist determines the date of admission, the approximate number of days needed for the hospitalization, and notifies the counselor.

- The length of stay will be established and used to authorize hospitalization. Include the admitting date and estimated ending date on the IPE.

- Hospitalization is limited to a maximum of 21 days during any 12 month period, excluding diagnostic hospitalization. This limitation must be clearly understood by the client and the vendor before the service is initiated, and must be stated on the IPE
    - Exception: A request for extension can be made if complications arise from a medical procedure authorized during the initial 21 day period. Send the written request with an explanation to the Client Services Section. Attach a copy of the approval memo to the authorization in the case file.

1130.3 Convalescent Care

- Following the provision of physical restoration services, and upon recommendation of the attending physician/approval of the medical consultant, convalescent care may be provided in a licensed facility/nursing home.

- Convalescent care is limited to 14 days during any 12 month period. A request for extension can be made if complications arise. Send the

written request with an explanation to the Client Services Section. Attach a copy of the approval memo to the authorization in the case file.

1130.4 Authorization and Billing

- Follow guidance provided in CSG Section 700.

- Diagnostic Hospitalization
  - Medicaid establishes a per diem rate for hospitals which will be accepted as payment in full.
  - Per diem rates are established for each hospital and are available in the Frequently Used Procedure Codes list.
  - Use Procedure Code 99999980.

- Outpatient Hospitalization
  - One day surgery is payable at 60% of actual charges, and authorized utilizing Procedure Code 99999981.
  - Enter $500.00 as the estimated amount on the authorization.
  - When the bill is received, amend the authorization to 60% of the actual charges billed.

- Inpatient Hospitalization
  - Use the Medicaid per diem rate multiplied by the anticipated length of stay.
  - Per diem rates are established for each hospital and are available in the Frequently Used Procedure Codes list.
  - Authorize using Procedure Code 112113700

- Private Insurance, Medicare and/or Medicaid
  - Any payment by private insurance must be deducted from the amount authorized, as well as any required client or family financial participation.

- Medicare and/or Medicaid must be applied toward the cost of hospitalization.

- If the dollar amount of Medicare participation can be determined, use the appropriate Procedure Code for the service. Enter the net amount payable by VR after Medicare participation.

- If the vendor accepts Medicaid, then the Medicaid payment must be accepted as payment in full.

- Hospitalization cannot be authorized for a client who is eligible for Medicaid unless the length of stay necessary to treat the condition is greater than the length of stay established by Medicaid. The difference may be authorized at the per diem rate. Maximum Medicaid benefits must be used before agency participation.

- Convalescent Care
  - Authorize according to Medicaid rates.

  - An authorization should not exceed a 14 day period, unless an exception has been approved.

1140 PROSTHETICS AND ORTHOTICS

1140.1 Guidance

- Prosthetics include, but are not limited to, the provision and repair of prosthetic and orthotics such as prosthetic limbs and braces.

- Implantable prosthetics include, but are not limited to artificial hip joint, knee joint, etc., and are typically associated with a surgical procedure through the hospital.

- Personal adjustment training may be provided when necessary. This may include training in the use of the prosthesis, stump conditioning and exercising in preparing the stump for fitting of the prosthesis, and gait training.

- May be provided upon the recommendation (prescription and specifications) from a physician, orthopedist, or physiatrist.

- These services are based on financial need.
- Apply any comparable benefits (if available).
- Prosthetic and orthotic devices should be checked by the physician, orthopedist or physiatrist following the fitting to ensure suitability. Obtain a written report of this follow up for case file documentation.
- Prior to payment, follow up with the client to ensure the fitting is satisfactory.

1140.2 Wheelchairs

- Wheelchairs are considered Rehabilitation Technology (see CSG Section 1900).

1140.3 Authorization and Billing

- Follow guidance provided in CSG Section 700.
- All prosthetic and orthotic appliances should be authorized using the established HCPCS rate as found in the case management system.

1150 DENTAL SERVICES

1150.1 Guidance

- Dental services may be provided when necessary to assist the client in reaching their employment outcome.
- Dental services may include costs to dentists or dental clinics for dental services such as fillings, extractions, bridges, orthodontia, and oral surgery, prophylaxis, dentures, and treatment of infections of the gum or related tissues (exclusive of dental examinations).
- Dental services may be provided when one of the following conditions is met:
  - Severe dental conditions exist that adversely affect the client's appearance and employability, and the counselor identifies it as the major disability.

- Severe dental infections exist that adversely affect the client's major disability, and the counselor identifies it as a secondary disability.
- Required emergency treatment for an acute dental condition that adversely affects a client's training program (inter-current illness).

- VR does not provide routine or preventative dental services.

1150.2 Authorization and Billing

- Follow guidance provided in CSG Section 700.

1160 EYEGLASSES AND VISUAL SERVICES

1160.1 Guidance

- Eyeglasses and visual services may include costs for optometric and/or ophthalmological eye examinations, eye glasses and the cost of repairs.
- Eyeglasses and visual services may be provided when it can be demonstrated that the client requires these services in order to successfully participate in vocational evaluation/assessment, training, or other primary VR services.
- Eyeglasses and/or visual services provided when the client is in Service status are based on financial need. Appropriate financial documentation is required.
- Eye examinations and eyeglasses provided to support diagnostic services are not based on financial need.

1160.2 Authorization and Billing

- Follow guidance provided in CSG Section 700.

1170 PSYCHOTHERAPY

1170.1 Guidance

- Psychotherapy services may be authorized when required for the eligible individual to begin or continue a rehabilitation plan under the following conditions:
    - The counselor has documented a search for comparable services through DMH or a local mental health provider.
    - The need for psychotherapy is clearly related to the expected employment outcome and recommended by a Missouri licensed psychiatrist or psychologist;
    - An Individualized Plan for Employment (IPE) must have been developed or be in the process of development to provide services leading to the attainment of the employment outcome;
    - The eligible individual meets VR's financial need guidelines;
    - The provider must be a Missouri licensed psychiatrist, psychologist, clinical social worker or professional counselor. The provider must possess a valid, unencumbered, unrestricted and undisciplined Missouri license; and
    - Psychotherapy may be authorized for a period up to three (3) months. An additional three (3) months of therapy may be approved if the therapist feels that the client is making satisfactory progress that will lead to the attainment of the employment outcome specified on the IPE.

1170.2 Authorization and Billing

- Follow guidance provided in CSG Section 700.