

## **3800 DIAGNOSTIC AND TREATMENT SERVICES**

**3801 General.** Diagnostic and treatment services may be provided as necessary to correct or substantially modify a physical or mental impairment that constitutes a substantial impediment to employment.

### **3802 Diagnostic Medical and Psychological Services**

**3802.1 General.** When the interview and result of the *Health Assessment Questionnaire* and subsequent medical evaluation clearly establishes that no vocational impediment arises from the disability or the resulting vocational impediment does not meet the severity level of “substantial,” and the individual clearly understands the absence of impairment, no further evaluation is needed. If, however, the individual continues to express a desire to receive consideration for eligibility, the Counselor will need to obtain necessary medical or psychological information for eligibility determination.

**3802.2 Health Assessment Questionnaire.** The *Health Assessment Questionnaire* will be completed in every case. During the preliminary assessment, diagnostics need only address the applicant’s vocationally relevant conditions. Unless a *General Medical Evaluation* is deemed necessary, the *Health Assessment Questionnaire* suffices as the appraisal of the applicant’s medical health.

A. *Description.* The *Health Assessment Questionnaire* is a series of questions involving an individual’s medical history, previous hospitalizations, treating physician(s), medications, medical restrictions, medical complaints, and/or treatments.

B. *When Completed.* The *Health Assessment Questionnaire* is to be completed by the Counselor at the time of the individual’s application, based on information received from the individual. If there is any question of the individual’s mental competency, as with an individual with a disability of mental impairment who may not have sufficient knowledge of his/her medical history to accurately respond to the *Health Assessment Questionnaire*, it will be necessary to obtain this information from the individual’s parent, guardian, or representative.

C. *Individual’s Statement of Disability.* The individual’s statement of his/her disability, its duration, and specifically how s/he has experienced it to limit function and prevent him/her from working will be recorded on the *Health*

*Assessment Questionnaire.* The foregoing is recorded to enable the examining physician to ascertain the compatibility of the individual's perceived incapacity with the functional loss expected in view of the physical findings. When the interview clearly establishes that no vocational impediment arises from the disability or that the resulting vocational impediment does not meet the severity level of "substantial," and the individual clearly understands the absence of impairment, no work-up is needed. If however, the individual continues to express a desire to receive consideration for eligibility, the Counselor will need to obtain necessary medical or psychological information for eligibility determination.

**3802.3 General Medical Evaluation.** The *General Medical Evaluation* assesses the existence, nature, and rehabilitation implications of the disabling condition(s) and the individual's overall health, in addition to the stated functional limitations which may influence the eligibility decision or formulation of the rehabilitation plan. Vocational implications include the current functional level; the potential for medical treatment to improve function and how much; and the probable course of the disorder.

A. *Counselor Actions.* The Counselor will record on the *General Medical Evaluation* the description given by the individual as to how s/he has experienced the impairment to prevent him/her from working. The Counselor also will record the medical history details (what, when, and current status) of all questionable or positive responses from the *Health Assessment Questionnaire*. The Counselor will enter remarks, questions, or requests for the examining physician. Examples of the type of specific questions/comments that can greatly help the Counselor include:

1. Are there medical contraindications to a trial work period involving considerable heavy lifting?
2. Does clinical evidence appear to substantiate the individual's statement of inability to stand for more than 5 to 10 minutes?

B. *Examining Physician Actions.* The examining physician will complete the *General Medical Evaluation* with the following:

1. A statement as to the individual's medical complaint;
2. Follow-up on any item of possible major current importance revealed by screening the medical history (may be indicated by such entries as further history on the question, comment as to its significance, diagnosis

explaining the finding, or a recommendation for further diagnostic study relevant to the question);

3. Distant vision, blood pressure, results of urinalysis and the findings upon physical examination of the body area of the complaint (heart, lungs, abdomen, and limbs);

4. Diagnosis, impressions, or recommended additional medical evaluations needed to reach a diagnosis;

5. Probable functional limitations (unless these are obvious, as in the diagnosis of blindness, deafness, amputation, or paraplegia) to the extent that these can be assessed;

6. Any medically contraindicated functions or environments (often there are none); and,

7. Treatment that may be helpful, if any, or further medical evaluation needed.

#### **3802.4 Specialty Consultations**

A. *General.* The consultation differs from the routine office visit in that the physician must provide an evaluation of the individual condition and a report which includes the diagnosis and prognosis with a treatment plan. Likewise, specific tests such as refraction and audiometry do not constitute consultation.

##### *B. When Needed*

1. Specialist consultation is arranged when there are questions about medical aspects of the case with possible vocational significance and those questions are not adequately answered by the *General Medical Evaluation* or existing medical information. The fact that an impairment lies within the subject area of a particular medical specialty does not of itself call for referral to that specialty, except for determination of eligibility for visual and hearing impairments. Questions about an impairment that confidently can be judged to be of no material vocational significance do not require specialty consultation.

2. Normally, specialty consultations are arranged after completion of *Health Assessment Questionnaire* and/or receipt of other medical information,

because these reports will help identify consultative needs, if any. When it is highly likely that specialist consultation will be needed, however, it may be arranged without regard to sequence.

3. The *General Medical Evaluation* or physician's report may recommend further tests or consultations, usually to refine the diagnosis or to advise or initiate a treatment plan. The Counselor will determine if these recommendations have vocational significance and, if not, document why the recommendation for further tests or consultations was not followed. If the recommended consultations are vocationally significant, the Counselor and the individual will select the consultant and determine the specific outcome needed. The Counselor also will determine if s/he has the critical medical information which is needed to determine eligibility, develop a rehabilitation plan, and, in a few specific disabilities, meet stated consultative requirements.

### C. *Obtaining Needed Information*

1. The Counselor must identify and communicate specifically to the consultant what s/he needs to know. The field medical consultant in many instances can help to identify and pose specific questions.

a. Following is an example of a Counselor question likely to result in the needed information: "Should we presume that the individual's current seizure frequency is about as good as can be achieved, or are further drug/dosage trials indicated?"

b. Conversely, here is an example of a Counselor statement that has a high risk of **not** resulting in the needed information: "Neurological opinion is needed to help establish eligibility, vocational objective, and rehabilitation plan."

2. The Counselor will ascertain that there are no identifiable obstacles to the individual keeping the scheduled appointment, such as transportation, childcare, individual's ambivalence on necessity, and location of the specialist's office. S/he will log the appointment in the *Action/Details* section.

3. The Division is responsible for providing the specialist with a synopsis of the relevant reports on file that may bear on the evaluation and a written statement to the consultant giving guidance as to the specific question prompting the consultation request.

4. In addition to authorizing the consultation itself, the Counselor also will authorize any x-ray and/or laboratory procedures usually required in the particular type of consultation.

*D. Specialist Report*

1. *Elements.* The consultant specialist report should contain the following:

- a. Brief medical history about the impairment;
- b. Brief description of the physical findings relevant to the impaired area;
- c. Diagnostic impression or listing of specific additional evaluation procedures needed to reach a diagnosis;
- d. Listing of specific functional limitations;
- e. Treatment recommendations, if any, or additional evaluative procedures needed to better reach this decision (reporting of the degree of functional or prognostic change anticipated as consequence of treatment should be suggested or recommended to consultants);
- f. Any medically contraindicated environments or situations or functions hazardous to health;
- g. A prediction as to the probable course which the disorder will follow (whether stable, progressive, self-limited or intermittent, and estimated timetable if progressive); and,
- h. Adequate response to specific questions asked by the Counselor.

2. *Standards.* In most cases, information on all eight of the above items will be needed. However, there are individuals for whom one or more of the above items will have been described adequately in other medical reports, or is self-evident, or is irrelevant to the issue prompting the consultation, or is otherwise not needed. Whenever the Division's information needs are met by the

consultation report singly or in combination with other reports, the consultation report should be regarded as meeting standards.

E. *Mandatory Specialist Consultations*

1. *Visual Impairments.* When a visual impairment is the major disabling condition or a significant secondary disability, a specialist consultant or visual examination will be obtained from an ophthalmologist or optometrist, whichever the individual may select. Counselor judgment allows for additional medical evaluations as circumstances warrant.

a. *Disease of the Eye.* When disease of the eye is present, any treatment authorized by the Division will be provided by or under direction of an ophthalmologist.

b. *Blindness.* When blindness is the disability, an audiologist or otologist will evaluate the individual's hearing. If an air conduction audiogram performed under the supervision of either is normal, this requirement necessitates no further evaluative measures. The Counselor for the Blind is not required to purchase additional ophthalmologic testing for individuals who are totally blind.

c. *Additional Tests.* Some ophthalmologists and optometrists include such tests as tonometry and slit lamp examination routinely in patients for whom they perform a refraction. When a practitioner states to the Division that his/her standard includes such procedures for all private patients, for those above a certain age, or for all new patients, the Division will not request him/her to deviate from that standard for its consumers.

d. *Payment.* The report received after such examination must relate the findings of each examination component on the authorization in order to be processed at that payment rate. If a lesser scope of examination is reported, payment will be at the level appropriate for that scope and the Counselor will advise the examiner of the basis for payment.

2. *Hearing Impairments.* A visual examination is required for individuals with deafness or a severe hearing loss as a primary or secondary disability impairment when one of the following is met:

a. at least a 55 dB loss, unaided, speech reception threshold (SRT) in the better ear; or,

- b. at least a 55 dB loss, unaided, pure tone average.

### **3803 Restoration and Treatment**

**3803.1 Health Maintenance Restrictions.** When the individual has long-term health maintenance needs that will continue subsequent to the delivery of planned rehabilitation services, such as ongoing medical management or routine replacement and repair of appliances, the Counselor shall advise and assist the individual in developing a plan of action for providing these services in the future. Strategies for setting aside funds on a monthly basis and utilization of community-based services are only two of many options. The Counselor will document the individual's plan of action in the rehabilitation plan.

### **3803.2 Special Considerations for Treatment and Services**

#### *A. Dental Treatment and Orthodontic Services*

1. *Eligibility.* Dental or orthodontic disorders are not considered substantial impediments to employment for purposes of determining eligibility. Any request for administrative exception must be submitted through supervisory channels for approval by the Deputy Director, Field Services *prior to determination of eligibility.*

2. *Intercurrent Illness.* Dental or orthodontic services may be provided when the Counselor documents that such services are necessary to address an intercurrent illness which, if not cared for, would complicate or delay the individual's rehabilitation program.

#### *B. Visual Physical Restoration Services.* In accordance with provisions of this section, visual physical restoration services may be provided as either a primary or support service when necessary to enable the consumer to complete a rehabilitation program.

1. *Eye Surgery.* When eye surgery is provided as a primary service, the individual will receive services from the Counselor for the Blind and Visually Impaired. Prior to developing the rehabilitation plan or amended plan for eye surgery, a medical report is required from the ophthalmologist who will provide the surgery. Contained within the report will be a diagnosis, reason for the surgery, expected outcome, and anticipated recovery time for the individual.

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a. *Surgery for Progressive Eye Conditions.* Eye conditions such as cataracts, secondary cataracts, detached retina, and others may be considered degenerative because without surgical intervention vision will continue to decline in the affected eye(s). Examples of eye surgeries with routinely positive outcomes of restoring vision to within normal limits include, but are not limited to: cataract extraction with lens implant, YAG capsulotomy (removal of secondary cataract), cryosurgery for detached retina, and scleral buckle (reattachment of detached retina).

b. *Surgery to Stabilize Eye Condition.* Eye surgery may be necessary to stabilize an eye condition. Some examples include laser treatment or vitrectomy for diabetic retinopathy or glaucoma.

c. *Surgery to Correct Physical Appearance.* Eye surgery may be provided as a primary service when medical records substantiate evidence of the condition's severity and/or subsequent health problems and when the Counselor documents that any of the following criteria is fully met:

(1) The eye condition is so severe that it constitutes a significant health problem which without treatment may prevent an individual from obtaining or retaining employment; or,

(2) The eye condition results in a cosmetic impairment so severe that the individual's employment is improbable; or,

(3) When necessary to support more critical surgical procedures.

2. *Provision of Ocular Prosthesis.* An ocular prosthesis may be provided as a primary service when medical records substantiate evidence of the condition's severity and/or subsequent health problems and when the Counselor documents that any of the following criteria is fully met:

a. The eye condition is so severe that it constitutes a significant health problem which without provision of an ocular prosthesis may prevent an individual from obtaining or retaining employment; or,

b. The eye condition results in a cosmetic impairment so severe that the individual's employment is improbable; or,



c. When necessary to support more critical surgical procedures.

C. *Hospitalization.* Services provided in a hospital will be purchased with an approved rehabilitation plan only in conjunction with surgery or treatment. Hospitalization will not be provided for diagnostic purposes or when in conjunction with a diagnostic surgical procedure. When hospitalization is recommended, the Counselor will obtain from the physician an estimate of the number of days that hospitalization will be required and the services to be provided. A copy of the official hospital report (discharge summary or similar report) will be placed in the case record.

D. *Intercurrent Illness.* Medical care for intercurrent illnesses may be provided by the Division only when acute illnesses or injuries occur during the course of an individual's rehabilitation or trial work experience which, if not cared for, would complicate or delay the individual's program.

E. *Nursing Services.* Nursing services will be purchased only when necessary for medical recuperation within the home as recommended by the attending physician, and only on a time-limited basis. Home health care or home nursing will not be provided for long-term care purposes.

F. *Orthotic Devices.* Orthotic devices will be purchased only when recommended and prescribed by a physician. A copy of the written prescription will be placed in the record.

G. *Physical and Occupational Therapy.* Physical and occupational therapy will be purchased from licensed individuals or facilities only with a prescription from a physician, a copy of which will be placed in the record.

H. *Prescription Drugs.* Prescription drugs may be authorized only by the Counselor when the prescription is directly related to the primary or secondary disabling condition, or when necessary to treat an intercurrent illness that is interfering with the individual's ability to complete the planned services. In either instance, the Counselor will emphasize to the individual that the service is time limited and only for the time necessary to reach a successful rehabilitation outcome. Prescriptions for routine health care that are not related to the disability will be the responsibility of the individual. Examples of routine health medications include seasonal allergy medication, antacids and other digestive aids, cholesterol

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control medications, hormonal supplements or other drugs prescribed for general health or medical purposes.

I. *Prosthetic Devices*. Prosthetic devices will be purchased to assist an individual to function independently. The following procedures apply:

1. Before authorizing for an initial fitting of a prosthesis, the individual must be examined by a physician and a copy of the recommendation for the prosthesis must be obtained from the examining physician. Replacement of existing prostheses for amputations resulting from conditions other than circulatory disorders does not require physician supervision unless requested by the prosthetist or the individual.

2. Individuals with amputations resulting from diabetes, Buerger's Disease, or other circulation disorders will be examined by a physician specializing in internal medicine before a prosthesis is authorized.

3. Individuals will be referred to approved and certified prosthetic providers after the medical examination is completed.

4. A prescription with specifications and cost of the prosthesis will be obtained from the provider prior to provision of the prosthesis. A copy of the prescription will be placed in the individual's record of services.

J. *Psychotherapy*. Psychotherapy will be purchased for an individual by the Division up to 20 sessions per year. Anything over that threshold requires District Manager approval and only when the following conditions are met and documented in the record:

1. A written recommendation from a psychiatrist or licensed psychologist is obtained; and,

2. Periodic progress notes recommending additional therapy sessions are required for continued sponsorship.

K. *Renal Dialysis*. Renal dialysis will not be authorized.

L. *Speech and Hearing Therapy*. Medically directed speech and hearing therapy will be purchased from a licensed specialist or qualified speech pathologist

to improve or eliminate the individual's disabling condition. A copy of the report shall be placed in the record of services.

M. *Surgical and Medical Treatment*

1. *General.* Surgical treatment may be purchased with an approved rehabilitation plan when directly related to the consumer's primary or secondary disability (the disabling condition(s) upon which eligibility was established) and is necessary to lessen or alleviate a functional limitation so severe it results in a substantial impediment to the consumer's employment. Surgical and medical treatment shall require a written report, including recommended procedures, by a licensed physician. It will be the responsibility of the physician to discuss with the individual the recommended procedures, implications, risk, and expected results.

2. *Cosmetic.* Cosmetic surgery or cosmetic procedures may be provided with an approved rehabilitation plan only when the consumer's vocational goal requires interaction with the public and there is a significant cosmetic defect resulting from injury, disease, or congenital malformation that constitutes a disabling condition for eligibility purposes and is so severe it results in a substantial impediment to the consumers employment.

3. *Body Invasive Procedures.* Body invasive surgical procedures such as cardiac catheterization or exploratory laparotomy performed to diagnose or to prepare for other potential surgical procedures may be considered with an approved rehabilitation plan.

4. *Exclusions to Surgery.* Certain surgical procedures normally will not be authorized by the Division. These exclusions include, but are not limited to the following:

- a. Sterilization;
- b. Abortions;
- c. Organ transplants;
- d. Operative or other medically prescribed procedures for sex changes;
- e. Prosthetic breast implant;

f. Hair electrolysis except for eyelashes abrading the cornea;  
and,

g. Hair transplant.

5. *Bariatric Surgery*. Bariatric surgery may be considered after the following criteria have been met:

a. All third-party insurance or resources have been explored.

b. Diagnosis of morbid obesity from a doctor of internal medicine or nationally certified in weight management/obesity.

c. Documentation of a Body Mass Index (BMI) over 40 for at least the past 5 years.

d. Documentation from the physician, indicating recommendations for Bariatric Surgery, including substantial inability to perform normal activities with functional limitations that present obstacles to employment.

e. Documentation from the physician within the two (2) years prior to the request for bariatric surgery, the referral must have participated in a physician supervised nutrition and exercise program, over a consecutive 12 month period, including consultation with a licensed dietician, an increase in physical activity, and behavioral modification is required. The weight loss must be maintained until the request is approved and/or the surgery is performed. This program must be documented in the medical record and the patient's program must meet the following criteria:

1. There must be a mandatory 10% weight reduction, demonstrated with consistency over a consecutive 12 month period. If pharmacotherapy is utilized to assist with weight loss during this 12 month period, the referral will be considered ineligible.

2. The weight loss program **must** include nutrition and exercise components with monitoring by a physician. **NOTE:** A summary letter will not be an acceptable substitution for medical records.

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f. Determine the individual is physically/mentally able to have surgery (prior to a surgery date being set), through pre-operation services and documentation of medical clearance performed by an appropriate Specialist and/or Physician. Psychological Evaluation must be performed by a Licensed Psychiatrist or Psychologist, independent of any association with the Bariatric Surgery Facility and should occur within 6 months of the scheduled surgery. The following are examples of pre-operation assessments/services and would require pre-authorization:

1. The psychological evaluation must include documentation of the consumer's ability to cope with major dietary, behavioral, and lifestyle changes, as well as evidence of adequate network/family support for the consumer, which are necessary to facilitate successful weight loss and maintenance;

2. Documentation of medical clearance for this surgery performed by an appropriate specialist, such as a Cardiologist or a Pulmonologist, to ensure the patient can withstand the stress of the surgery from a medical standpoint; and,

3. Medical studies, such as laboratory tests, electrocardiograms, and x-rays or other radiological procedures.

g. Individual must be tobacco free for a minimum of six months to reduce possible surgical complications and risks of mortality.

h. The individual has never undergone bariatric surgery before. Those failing to lose weight from a prior procedure will not be approved for a second surgery. Only one procedure will be covered by the Division per lifetime.

N. *Wheelchairs.* Wheelchairs will be purchased only when prescribed by a physician. A copy of the wheelchair prescription or written specifications for the wheelchair signed by an authorized prescriber will be placed in the record of services. Authorizing procedures will be followed when purchasing wheelchairs.

O. *Chiropractic Treatment.* Payment for chiropractic services is specifically limited to treatment by means of manual manipulation of the spine (i.e., by use of hands only). No other diagnostic or therapeutic service furnished by a chiropractor or on his/her order may be covered by the Division. Other services such as x-rays, office visits, manipulation of body parts other than the

spine, and other diagnoses not related to the spine, are not covered when performed by a chiropractor. Manipulative treatment must be determined medically necessary and recommended by a physician other than the chiropractor and supported by the existence of x-ray documentation. Periodic progress reports will be obtained from the chiropractor to ensure treatments are resulting in medical improvement. Chiropractic treatments may be authorized for a maximum of twelve treatments per calendar year. Treatments beyond the initial twelve may be provided only upon recommendation from the original referring physician and are limited to a maximum of twenty-four over a period of two calendar years. Under exceptional circumstances, the Counselor may authorize additional treatments with approval of the Deputy Director, Field Services.

P. *Provision of Hearing Aids and Devices.* Hearing aids can be provided if directly related to the individual's ability to enter gainful employment or maintain gainful employment commensurate with the chosen vocational goal indicated on the rehabilitation plan. The primary function of the hearing aid is to amplify and enhance residual hearing of the individual with hearing loss; it does not restore lost hearing. The technology involved with hearing aids changes rapidly and it is important that the individual's employment related communication requirements and the available options are understood when providing amplifications.

#### 1. Eligibility for Hearing Aids

a. *Functional Limitations.* The functional limitations in communication must result in a substantial impediment to employment. In order for an applicant to meet the eligibility criteria for substantial impediment to employment and be provided hearing aids, the applicant must demonstrate functional limitation(s) in communication, such as difficulty understanding speech, inability to participate in conversation without speech reading, sign language or other visual cues, cannot interpret telephone conversation, cannot hear or understand the content of spoken conversations or cannot be readily understood by others.

b. *Verified Conditions.* The applicant also must experience at least one of the following conditions as verified by a licensed audiologist:

(1) Average pure tone loss of 40 dB (ANSI) or more in the worst ear in the speech range (500, 1,000, and 2,000 cycles per second), unaided; or

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(2) Average pure tone hearing loss of 20 dB (ANSI) or more in the better ear in the speech range when pure tone average loss in the other ear exceeds 80 dB (ANSI), unaided; or

(3) Speech discrimination of 80%, or less, at the Most Comfortable Level (MCL) in an unaided environment regardless of pure tone average loss; or

(4) Rapidly progressive and/or chronic condition not contingent upon decibel loss in either ear, as verified by an Audiologist. If the Audiologist determines a referral to an ENT is necessary, the Division will participate in the cost of the evaluation. If the consumer is 18 years of age and under, medical clearance for hearing aids is required from the ENT.

*c. Exceptions.* Exceptions to the eligibility criteria for provision of hearing aids or devices will be submitted to the Deputy Director, Field Services through supervisory channels for review and approval.

2. *Replacement of Hearing Aids.* The Division will replace current hearing aid(s) only when the individual has met the eligibility criteria in this section and has shown that the aids have been cared for properly, have not been misused or neglected. If they are seeking replacement aid(s), individuals need to demonstrate that they have followed the manufacturer's instructions and appropriately cared for the hearing aids by submitting documentation of records showing repairs or annual checks of the aids. Hearing aids may be replaced if the individual's hearing aids meet one or more of the following criteria:

a. The aid(s) no longer work to specification and repairs will not restore the aids to proper working order; or

b. The individual's hearing loss has changed significantly requiring different amplification; or

c. The communication needs of the job have changed requiring different amplification.

3. *Repair of Hearing Aids.* The Division will not participate in paying for repairs for hearing aid(s). Repairs are considered normal upkeep and care for the aid(s) and are the responsibility of the individual. It is expected that the individual will plan for regular care and upkeep, including repairs, and

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planning for the cost of repairs should be included as part of their rehabilitation plan. Any exceptions must be approved by the Deputy Director, Field Services through supervisory channels.

4. *Considerations in Purchasing Hearing Aids.* Certain considerations will be noted by the Counselor of Record, including the following:

a. *Vocationally Necessary.* The Division will only purchase hearing aids that are vocationally necessary for an individual to obtain or keep their employment status. The Division will not participate in additional costs for features chosen by the individual that are not required for their employment-related communication needs. The Counselor of Record must ensure that the audiology report indicates what treatment recommendations are made for the individual and why the individual would benefit from these devices given their employment environment.

b. *Warranty*

(1) The individual is responsible for any and all deductible costs associated with loss/damage and/or stolen claims.

(2) The Division will not purchase an additional warranty for loss, damage, and/or repair beyond what the manufacturer provides when the hearing aid(s) are purchased.

c. *New Technology.* The Division will not purchase hearing aids based on technology changes merely because the consumer prefers new technology.

5. *Required Diagnostic Evaluations.* Diagnostic evaluations will include the following:

a. *Audiological.* The Division will only accept comprehensive audiometric evaluations performed by licensed audiologists. The audiological evaluation must utilize American National Standards Institute (ANSI) standards, and include both tympanometry and a hearing aid selection and fitting evaluation. Additional evaluations may be provided during assessment if needed, such as a tinnitus assessment.



*b. Otolaryngological.* The Division will only accept otological evaluations performed by otolaryngologists (ENT), physicians especially skilled in diseases of the ear. The otolaryngological report will include information regarding etiology of the hearing loss, diagnosis, and verification as to if the consumer is medically cleared for amplifications.

6. *Vocational Counseling and Guidance and Plan Development.* Hearing aid(s) alone seldom resolve the communication barriers and other disability issues experienced by individuals with hearing loss, therefore, further discussion of the individual's functional limitations, coping skills, and accommodations, are necessary. The case record must document the need for and provision of counseling concerning functional limitations, coping skills, and accommodations relevant to the identified disability of hearing loss or deafness.

*a. Communication Assessment.* For first-time wearers, the Counselor of Record (COR) will complete the *Communication Assessment* with the individual.

*b. Counseling.* Individuals who will be using hearing aid(s) for the first time will need counseling in a variety of areas to ensure adjustment to the amplification. In addition, the Counselor of Record (COR) will provide counseling to first time wearers of hearing aids regarding the following:

(1) Adjustment to the hearing loss, including helping the consumer understand the social stigma of wearing a hearing aid, accepting it may not "fix" every communication problem, and the need to assertively request good communication behaviors from others; and

(2) Self-advocacy, including being aware of his/her rights under ADA and how to discuss the effects of hearing loss and necessary accommodations with coworkers, supervisors and employers as needed: and

(3) Communication strategies, such as learning how to assess and modify communication barriers in the workplace; and

(4) Information on assistive technology, including awareness of other devices, techniques, and resources for improving communication.

## 7. *Provider Requirements*

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a. *Criteria.* When considering purchase of hearing aids, the Rehabilitation Counselor for the Deaf (RCD) or Counselor of Record (COR) will utilize providers who have met the following criteria:

- (1) A licensed audiologist; and
- (2) A licensed physician specializing in diseases of the ear, nose, and throat.

b. *ANSI Standards.* All providers must utilize American National Standards Institute (ANSI) standards.

c. *Memoranda of Understanding.* The Division has Memoranda of Understanding with Oticon, Phonak, Siemens, Widex, Resound, and Starkey, as well as their affiliates. These agreements include hearing aid accessories and FM/ALD. Extended warranties are included in the agreements. Purchase of a hearing aid from any other manufacturer will require an exception from the Deputy Director, Field Services through supervisory channels.

Q. *Provision of Cochlear Implants and Processors.* The use of cochlear implants has been a successful type of therapy for those with severe to profound sensorineural hearing loss and for those who are unable to be helped with conventional hearing aids. If it has been determined that all other treatment options, as documented by an ENT, will not reduce, circumvent, or alleviate the hearing impairment, and the cochlear implants or processors are vocationally necessary, then cochlear implants and processors may be provided on an exception basis when approved by the Deputy Director, Field Services through supervisory channels.

1. *Licensure and Specialized Training.* The physician involved in the cochlear implant surgery must be a board certified otolaryngologist, licensed by the state they work in, with specialized training in cochlear implants. The audiologist involved in cochlear implants must be licensed by the state they work in, with specialized training in cochlear implants.

2. *Assessment Criteria.* The following criteria will be met when assessing candidates for cochlear implants:

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- a. The consumer must have a severe or profound sensorineural hearing loss, and not be able to benefit from any type of hearing aid; and,
- b. The consumer must have post-lingual deafness, be of working age, and have the potential to become employable; and,
- c. If the deafness is pre-lingual, the consumer must demonstrate the ability to use speech for every day communication; and,
- d. The consumer must not have any mental or medical condition that would preclude optimal use of the cochlear implant such as: middle ear infections, cochlear ossification that prevents electrode insertion, absence of cochlear development, or tympanic membrane deformation; and,
- e. The consumer must receive prior counseling concerning benefits and risks of the cochlear implant and acknowledge the changes that may occur in one's life as a result of this procedure; and,
- f. The consumer, if qualified for the cochlear implant, must agree to attend all scheduled rehabilitation sessions, in addition to the initial programming of the speech processor, following the recuperation period after surgery; and,
- g. If a second device and speech processors are recommended, the Division will require an additional justification from the physician who specializes in cochlear implantation.

### **3804 Selection of Physical/Mental Restoration Service Provider**

#### **3804.1 Individual's Choice**

*A. Accepting Individual's Selection.* When there are no substantial reasons for a contrary action, the individual's choice of practitioner or facility for either evaluation or treatment will be honored.

*B. Reasons for Not Honoring Individual's Selection.* Reasons for making another selection include:

1. The provider does not meet the standards of licensure, certification, or accreditation;

2. The provider is unequivocally on record with the Division as not wishing to serve Division consumers or not serve in the situation at hand, such as a new patient, non-physician referral, or perform a certain surgical procedure; and/or,

3. The provider has been specifically determined as unsatisfactory by the Division on the basis of previous work for reasons which may include falsification of services rendered, inadequate response to Division attempts to get timely reports, inadequate evaluations, and significant shortcomings in competency judged on the basis of careful evaluation by Division medical staff.

**3804.2 Selection When No Doctor-Patient Relationship Exists.** Some individuals will not have a current relationship with a physician or any preference as to whom to see for needed medical services. In this situation, the Counselor should suggest several physicians appropriate for the service needed. In making suggestions, the Counselor should select names of physicians whose history of service to individuals has been highly satisfactory in terms of promptness of appointment and subsequent reports, completeness of evaluation, costs, geographic proximity and quality of performance.

**3804.3 Change in Physicians.** Within reasonable limits, the individual under Division sponsorship may change physicians upon request. Anxiety and loss of confidence not adequately restored by the Counselor's explanation may constitute an acceptable reason for change. In general, however, more than one change should prompt limitations on Division sponsorship, since inevitably a change results in some duplication of work and costs. More than one change raises a question of loss of effectiveness because of lack of continuity of care, suggests a need for counseling, and should prompt a careful assessment of whether Division funds are being spent wisely in sponsorship of medical services.

## **3805 Miscellaneous Provisions**

**3805.1 Individual's Consent for Surgical and Other Procedures.** The burden of responsibility for providing risk information lies with the service provider. The Counselor should advise the individual that the provider is the authoritative source of information about outcome and risk, and that the Division expects the individual and the provider to discuss such matters directly. Any release forms to be signed by the individual will be provided by the practitioner, with the individual's

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signature attesting to the individual's informed consent for the practitioner to provide the particular service.

**3805.2 Failure to Keep Appointments.** By statute, the Division cannot pay for a broken appointment. The Counselor will make every effort to preclude the individual from failing to keep an appointment.