Section 4 Medical Services

Part 1 Hearing Aids

Rehabilitation Services (RS) Policy and Procedure

Counselors shall discuss provision of hearing aids with clients and help clients determine which aids and audiological services best meet their needs. Clients (age 18 or older) who do not wish to wear aids when there would be no improvement in the ability to understand speech may make that determination. Or they may elect to use only one hearing aid for sound awareness. They may make this choice even though an audiologist or licensed hearing aid specialist may have recommended two aids. Counselors should assure that clients have the information needed to make an informed choice in such circumstances. Trial periods may be appropriate to help some clients determine if they can benefit from aids.

Clients should be shown the Client Hearing Aid Satisfaction Questionnaire. (Forms Part 25). It should be explained that no payment will be made to the vendor until the client is satisfied. The client should complete the questionnaire and the audiologist should return the completed questionnaire to RS along with the billing.

Purchase of hearing aids should be done within an Individualized Plan for Employment (IPE), either as a service provided to an accepted client (Statuses 14, 16 or 18) or as part of an extended evaluation (Status 06). Hearing aids should not be provided in Status 02.

Prior to dispensing a hearing aid, a hearing evaluation must be completed by an audiologist or a licensed hearing aid specialist if an audiologist is not available in the community. The hearing aid provider may recommend a medical examination by a licensed physician as required by the federal Food and Drug Administration to assure that all medically treatable conditions which may affect hearing are identified and treated before the hearing aid is purchased. The FDA requires the exam to be completed within the previous six months. Such a medical exam is required for all children. The FDA regulations permit a fully informed adult (age 18 or older) to sign a waiver statement declining the medical evaluation. Section II of the Hearing Aid Forms lists the eight medical conditions which indicate that referral for a medical exam is appropriate.

Hearing Aid Forms

Hearing Aid Provision, Medical Examination - Section Ia: If the hearing aid provider discovers a hearing disorder with an unresolved medical problem, a medical exam by a physician is required. Persons under the age of 18 must be examined by a physician prior to purchasing a hearing aid.

Hearing Aid Provision, Hearing Examination - Section Ib: This examination must be completed prior to dispensing a hearing aid. This section is completed by a clinical audiologist [Certificate of Clinical Competence (CCC-A) and state licensed] or a hearing aid specialist licensed to dispense hearing aids if an audiologist is not available in the community. This examination should consist of two CPT procedures:

- Comprehensive audiometry threshold evaluation and speech recognition
  925570000 at $52.93

- Tympanometry (impedance testing)
  925670000 at $7.56

Hearing Aid Provision, Certification for Hearing Aid Dispensing - Section II: The hearing aid provider identifies the hearing aid recommended and expected benefits and also certifies that the client has been advised to consult with a licensed physician (preferably an ear specialist) before the hearing aid is dispensed if the client has any of the eight medical conditions listed.

Hearing Aid Evaluation - Section III: The vendor evaluates the hearing aid fitting near the end of the 30-day trial period. The vendor should examine the client. If the client, vendor or counselor determine that the hearing aid is unsatisfactory, the vendor is to be paid only the trial fee for $50 for each hearing aid returned.

Client Hearing Aid Satisfaction Questionnaire - Section IV: The client completes this questionnaire after the trial period. This questionnaire, *Hearing Aid Evaluation - Section III Form* and the manufacturer's invoice are submitted to the counselor for payment.

The fee schedule separates costs for dispensing and for the hearing aid equipment.

- When a device is returned as unsatisfactory, RS will pay only $50 (no dispensing or equipment fees).

- The fee for the hearing aids will be reimbursed at the manufacturer's invoice cost. A copy of the actual invoice is required and should be provided by the vendor attached to the billing statement.

- The dispensing fee increases as the complexity of the device increases. A more complex device requires additional vendor equipment for adjustments and more follow-up visits.

Tier I: Traditional linear hearing aid
Estimated cost for hearing aid*: $400
Dispensing fee for the first aid: $250
Dispensing fee for the second aid: $100

Tier II: Advanced signal processing aid
Estimated cost for hearing aid*: $450
Dispensing fee for the first aid: $480
Dispensing fee for the second aid: $200

Tier III: Digital programmable aid
Estimated cost for hearing aid*: $850
Dispensing fee for the first aid: $800
Dispensing fee for the second aid: $400

** Use this estimated cost to prepare the authorization. This may be adjusted to a higher or lower cost at the time of payment depending upon the actual invoice cost. Note that economic need procedures must be applied to the purchase of hearing aids, and clients will be expected to contribute according to their ability to do so.*

Section 4 Medical Services

Part 2 Medical Procedures

Correct Medicaid Health Care Finance Administration (HCFA) and Current Procedural Terminology (CPT) codes are used to determine the amount to be authorized/paid for services, unless otherwise specified. With the exception of fees authorized in this manual for specific services, RS pays the Medicaid rate for medical services provided to clients as part of their IPEs. Medicaid payment is payment in full and no additional payment is authorized. Providers shall not request or accept additional payment from clients.

Medical card/other insurance: If the client has a medical card or other medical insurance, either Medicaid or the insurance must be used before Rehabilitation Services (RS) may pay. A Medicaid payment is payment in full and no additional payment may be made. If private insurance pays part of the bill, RS will pay the balance that would be charged the client up to the maximum Medicaid allows for a specific service. Providers shall not bill for any “write-offs.”

Payment: The physician or medical provider should provide the services authorized and should notify the counselor if any additional services are to be provided. Although RS may authorize a service by procedure code and description, the medical provider may change the code to indicate services actually provided in accordance with allowable established codes. If the code billed does not appear on Kansas Management Information System (KMIS) either with or without a rate, it is not valid. If the procedure code supplied by the provider allows less than the amount authorized, the lesser amount is paid.

All medical providers should be able to provide the proper procedure code (including modifiers necessary) for services they provide. Staff should not hesitate to request this information. All Kansas physicians and providers should have this information since it is needed to file insurance claims.

Non-covered Medicaid services: KMIS shows the amount Medicaid allows for a specific procedure. If the procedure code shows a blank, zero, seven or nine in the allowed cost, Medicaid does not cover the services or has special requirements. RS staff should verify with the provider that the non-covered Medicaid procedure code is the service actually provided. If the service was actually correct, the RS Administration Office should be contacted about the rate.

Anesthesia: All anesthesia services are paid by points indicated in the surgical procedure code with the modified code “IND” on KMIS. The “IND” number relative value (procedure code plus modifier) plus time in units of 15 minutes are added and multiplied by a conversion factor of $19.50.

Anesthesia Example: The procedure code of 66984-3000 has an “IND” code of 8 (relative value). If the time used of 121 minutes is divided by the 15 minute unit to determine time points, the time points would equal 9. A partial time unit is considered a full unit. Together the relative units of 8 plus the time units of 9 would equal 17 units times $19.50.

Medical Report/Definitive- $20

- A report the physician provides in response to a counselor's request. This report summarizes information rather than copying medical records only.

Medical/Hospital Records- $10

- RS counselors pay as billed up to a maximum of $10 for medical records, unless a regional exception has been authorized by the RS Program Administrator.
- Government agencies such as state hospitals, Veterans Administration, etc. provide records without charge.
- It is best practice to request only the most recent specific records needed for VR eligibility and planning purposes.

Medical Records Search Fee- $1.00 per quarter hour or portion thereof.

Payment for health insurance premiums
This is an allowable VR expense, if it is a cost-effective alternative to paying actual medical costs. An analysis of the cost effectiveness and search for comparable benefits must be included in the record of services.

Section 4 Medical Services

Part 3 Medical Examinations

General Medical (GENM) up to a maximum of $70 fee

- This includes a comprehensive history and physical exam with decision making of average complexity and is to include functional physical limitations and comprehensive report (all information completed on the general medical exam, including range of motion for low back questions). The counselor completes the Health Assessment Questionnaire as part of the referral information. This fee will be paid for the average, traditional medical examination and will be generally used for the payment of family practitioners and internal medicine practitioners providing the general medical exam.

- Primarily used by Disability Determination Service (DDS) staff, this exam is also used for a basic mental status exam provided by a psychologist. This exam is a clinical interview that provides a diagnosis and assesses the following areas of psychological functioning: history, thought content, affect, insight and judgment, intelligence, attention, concentration, appearance and behavior.

- Rehabilitation counselors should not use the GENM for purchase of psychological testing for intelligence and personality assessment. Refer to the psychological testing section (Section 4 Part 5).

Intermediate Examination (INTM) with payment up to a maximum of $85

- This examination is the same information as the general medical exam with additional information for a specific functional limitation not provided by a general medical exam. Also, this can be used in areas where the medical exam reimbursement is not adequate. Primarily, this examination fee and code are used for the following physicians specialties: internal medicine, rheumatology, physical medicine, pulmonary, nephrology and pediatrics.

Specialist Examination (SPECM) up to a maximum fee of $110

- This examination includes a comprehensive specialty history and physical with decision making of high complexity and to include functional physical limitations and a comprehensive report.

CODES

Cardiology CARDI
Neurology NEURO
Orthopedic ORTHO
Otolayrngology OTOLA
Pediatric Subspecialty PEDIA

Physiatric PHYSI
Psychiatry PSYCH

Section 4 Medical Services

Part 4 Miscellaneous Medical Services

Range of motion, back and extremities up to a maximum of $35
When available medical information does not include this information, purchasing a range of motion analysis versus a general medical exam is more cost effective. When a rehabilitation counselor purchases a general medical exam, the range of motion information is to be provided by the examining physician. The general medical exam with its range of motion provides an alternative to an orthopedic specialist exam.

Visual

- Basic eye examination by an optometrist. Not to exceed $106.75 OPTOM
- Eye examination and diagnosis by an ophthalmologist. Not to exceed $106.75 OPHTH
- Low vision examination $125 LVEX
- Goldman Visual Field examination $70 GOLDM

Eyeglasses

- Kansas Department for Children and Families (DCF) prudent person concept with maximum rate of $100 for frames. May use the WG modifier and pay “as billed” if needed.

Mental health

- Mental Health Centers are paid at the same rate as other providers for the same services.

Section 4 Medical Services

Part 5 Psychological Testing

Records from current and prior treating and evaluation sources should be obtained prior to ordering new psychological evaluations. As a general policy, the more extensive the treatment history, the less in-depth psychological evaluations are needed. If questions arise regarding the adequacy of the records or the need for further psychological evaluation, when feasible counselors and Program Administrators are encouraged to secure input from their District Psychological Consultant or the State Psychological Consultant.

With each referral for psychological evaluation, there must be documentation of the referral questions and rationale for the referral. Referral questions may typically appear in a referral letter to the psychologist whereas the rationale for the referral may only appear in the case record narrative. Referral questions and the rationale statement could also be included in the referral letter to the evaluating psychologist.

All reports must include the following information:

1. Date the testing was administered.
2. Who administered the testing?
3. Person who interpreted the testing and wrote the report submitted.
4. Time spent administering each test.
5. The total time spent on interpretation and reporting.

The following are psychological evaluation guidelines. Also included are common reasons for authorizing these procedures and maximum charges that are allowed. Individual psychologists may substitute their own preferred assessments to address the counselor's referral questions. The hourly rate for these services is $117. This means it includes service codes 170, 320 and 340. For psychotherapy services, please remember that services are authorized in increments of:

20-30 minutes - $58.50

45-50 minutes - $117

Mental status examination

- This is a clinical interview to confirm functional limitations for persons with a history of mental illness. This also may be used as an initial examination for clients who have reported work problems or presented unusual behavior during the initial interview with the counselor. If the mental status exam results indicate intellectual and personality assessments are needed, then additional evaluations would be authorized. This level of examination may be sufficient for rehabilitation facility referrals which need a current assessment of an already diagnosed disability. The mental status examination is an appropriate evaluation when the client's impairments appear overtly severe and when there is extensive but not current treatment history.

Intelligence testing up to a maximum of 2.5 hours

- This includes the Weschler Adult Intelligence Scale-Revised and the Stanford-Binet. It will not require the same amount of time to administer this testing to all vocational rehabilitation (VR) clients. In particular, clients with a diagnosis of mental retardation typically require much less time to administer this testing. Intellectual testing should only be ordered if there is a reason to suspect an intellectual deficit or learning disability. Intellectual testing may also be appropriate when a client is interested in pursuing an academic or training program that requires a certain level of cognitive ability; however, other sources of functional information such as school transcripts and prior work history should be utilized before ordering intellectual testing. IQ testing done after the age of 16 is considered to be stable throughout a person's adult life, assuming the original testing was a valid and reliable estimate and there were no intervening injuries or disease process that could result in a decline in cognitive functioning.

Standardized Achievement Testing up to a maximum of 2.5 hours

- In cases where a learning disability is suspected, the Woodcock-Johnson Achievement Battery is recommended. When achievement deficits are believed to result from academic underachievement or lack of education, the Wide Range Achievement Test may be sufficient (maximum of 1 hour).

Personality Assessment up to a maximum of 1 hour per test or 2 hours

- In situations where there is reason to suspect that a psychiatric impairment will interfere with work function or completion of a training or academic program, personality assessment such as the MMPI (1 hour) and/or projective testing such as the Rorschach or TAT (1 hour each) may be appropriate, particularly if there is a minimum of existing information.

Substance Abuse

- Refer to the local RADAC for assessment.

Neuropsychological assessment up to a maximum of 8 hours

Neuropsychological evaluation (such as the Halstead Reitan and Luria Nebraska) should be done very sparingly but may be appropriate in complex cases of head injury or learning disability.

Section 4 Medical Services

Part 6 Psychotherapy

Psychotherapy should only be funded by vocational rehabilitation (VR) when it is recommended by a licensed psychologist or psychiatrist and is provided by a licensed mental health professional. Psychotherapy by unlicensed professionals can only be funded if a licensed professional is providing supervision and is assuming full responsibility. The supervision arrangement needs to be documented in writing and all progress reports must be co-signed by the supervisor.

Because the definition and nature of psychotherapy varies greatly among qualified providers, it is often difficult to determine exactly what is being provided when psychotherapy has been authorized. Therefore, before therapy is authorized a statement should be obtained from the treating source that specifically outlines the following information:

1. The type or types of treatment modalities that will be employed.
2. The anticipated length of treatment that will be needed.
3. Treatment goals and the manner in which progress will be assessed and reported.
4. A statement of how the proposed treatment specifically relates to the vocational objective.
5. Prognosis and expected outcome.

Under most circumstances, VR should fund a maximum of 12 psychotherapy sessions (one hour sessions weekly over 12 weeks usually); however, an absolute limit of 12 psychotherapy sessions may be problematic because it may unfairly restrict the use of some potentially effective treatment modalities and may not adequately address the needs of clients with severe psychiatric impairments. Therefore, on an individual basis, additional psychotherapy sessions beyond the initial 12 session limit may be authorized as follows:

- 13 - 24 sessions require Regional approval. Each RS Program Administrator will establish a procedure for routing such exception requests through the RS Managers, RS Program Administrator or both. Use of the Exceptions Request Form (see Forms Part 54) is required..
- 25 - 48 sessions require approval by the State Psychological Consultant or Deputy Director.
- No more than 48 sessions can be funded.

Funding by other sources (i.e. self-payment, other insurance, or Medicaid-Medicare) would not be counted toward this limit. Also, once the 48-session limit is reached, there is no requirement that the client's case be closed. Other VR services could certainly continue to be provided if needed, although in such cases it may be advisable to seek input from the District and/or State Psychological Consultant.

Rates for psychotherapy provided by licensed physicians or psychologists:

20-30 minutes - $58.50

45-50 minutes - $117

See other Medicaid codes for services provided by licensed mental health professionals who are not physicians or psychologists.

Section 4 Medical Services

Part 7 Dental Services

Dental services are provided when the condition of the teeth and gums constitutes or contributes to a physical or mental disability which creates an impediment to employment. Dental services may be needed because of other disabilities which contribute to dental problems.

A program of general dental care is not allowed.

During the rehabilitation process a client may require preventive dental work such as filling of teeth. The intercurrent illness authority (including the cost cap) may be used for treatment of such acute dental problems which prevent continuation of the rehabilitation plan.

Some issues to consider when determining whether or not to provide dental services are:

- Many dental procedures can be successfully completed at different levels of care.
- Many dental procedures require specific, sometimes long term, follow-up care. Counselors and clients should know the extent of services necessary to bring about a desired outcome before beginning the process.
- Some dental procedures are temporary in nature and will require additional work in the future.
- Many dental procedures require the client to maintain a regimen of personal oral hygiene.
- When authorizing such services, the counselor should assure that the client understands the need to maintain adequate oral hygiene. It may be necessary to provide education on oral hygiene and the consequences of neglect, as well as assistance in developing the proper hygiene regimen, especially for clients who have a history of poor dental hygiene. One option for provision of such education is referral to an oral hygienist.

Dental services may be paid up to the usual and customary rate less 10%. This RS rate is subject to future change based on analysis of typical fees and usage. The appropriate CPT and service codes for dental procedures are required, just as with medical services.

The counselor may authorize fees above this rate if the total cost would be less expensive than the RS rates plus travel expenses to another community. In these situations, the cost savings must be noted in the narrative.

When dentists are not willing to provide services at the RS rate, an exception request must be approved. Each RS Program Administrator will establish a procedure for routing such exception requests through the RS Managers, RS Program Administrator or both. Use of the Exceptions Request Form (see Forms Part 54) is required.

Special procedures for dental surgery:

- The surgery analysis described above is required for oral and maxillofacial surgeries with American Dental Association (ADA) procedure codes D7260 to D7999.
- The surgery analysis is NOT required for ADA procedure codes D7000 to D7259. Therefore, most extractions will not require completion of the surgery analysis.
- The Counselor must get the ADA code from the dentist prior to authorizing the service in order to determine whether the surgery analysis is required.
- See Resources Part 29 for a copy of the ADA code listing.

Section 4 Medical Services

Part 8 Medical Procedure Codes

These types of procedure codes are used to obligate and pay medical expenditures.

- CPT Codes - Current Procedural Terminology (National Codes) - Physician Services.
- HCFA Codes - Health Care Finance Administration Common Procedure Code System (National Codes) - for use by a variety of entities; i.e., dental codes have a D prefix.
- Local Codes (Kansas Codes) - Eyeglasses are one example of local codes that have a Y prefix.

The three types of procedure codes listed above may be used by different providers to identify services provided to RS. Since all providers in Kansas must use the above codes to bill an insurance company (including Medicaid), the provider will be familiar with the codes for services they provide.

In some circumstances involving physician or hospital services, the procedure code may be located in the CPT manual using the following procedures:

- In the index, alphabetically find the procedure to determine the location of the manual. (Except for the physician office visits, physician hospital visits, and physician consultations (procedure codes 99201 through 99499) in the front of the manual, all other codes are in numerical order.
- If the procedure code needed is available, enter the code number and four zeros in KMIS to determine the rate.

Procedure code modifiers: A modifier code is a two (2) digit code that identifies a specific type of service, a variation of the service identified by the base code, for example, assistant surgeon, anesthesia.

The following are HCPCS modifiers:

PA Physicians Assistant
TC Technical Component - Applies to taking of the x-ray
WC Charge for clinic room and supplies for surgery not performed in a hospital.
WG Optical Services (Optometrists and Opticians) - Purchase of eyeglasses.
WP Specified Outpatient Procedures
26 Professional Component - Such as interpretation of an x-ray y a physician.
30 Anesthesia Services (General) (See the “IND” code on KMIS for procedure points).
50 Bilateral Procedures
80 Assistant Surgery

EXAMPLE: Anesthesia Services for an Appendectomy 449503000

Base Code for Appendectomy 44950
Modifier for Anesthesia Services 3000

EXAMPLE: Professional Component of Chest X-ray Procedure 710102600

Base code for Chest X-ray 71010
Modifier for Professional Component 2600

Section 4 Medical Services

Part 9 Hospitalization and Other Hospital Services

Inpatient and Outpatient Services

Reimbursement for inpatient and outpatient medical services provided by hospitals and surgical centers will be made at a variable discount rate based on the facility's Peer Group Classification. The discount rate will be applied to the facility's usual and customary charge.

Peer Group 1 — 15% Discount

Facilities in the following communities:
Kansas City
Lawrence
Olathe
Overland Park
Shawnee Mission
Topeka
Wichita

Peer Group 2 — 12.5% Discount

Facilities in the following communities:
Atchison
Augusta
Coffeyville
Dodge City
El Dorado
Emporia
Fort Scott
Garden City
Great Bend
Halstead
Hays
Hutchinson
Junction City
Leavenworth
Liberal
Manhattan
Newton
Paola
Parsons
Pittsburg
Salina
Winchester

Peer Group 3 – 10% Discount

All other facilities, including out-of-state facilities
All specialty hospitals, such as rehabilitation hospitals

Charges in excess of $40,000

In addition to the variable discount rate based on Peer Group Classification, an additional 5% discount will be applied to all charges that exceed $40,000.

Allowable charges

Allowable charges may include room charges, supplies used, lab or x-ray services. However, if a client is referred to a hospital for x-rays but is not actually admitted as an inpatient or outpatient, the x-rays will be paid by HCFA or CPT codes and at the rates allowed for those codes. If the hospital bills for physicians such as a hospital call or surgery, these services will be paid at by HCFA or CPT codes and at the rates allowed for those codes.

Durable medical equipment supplied by a hospital or surgical center

Items such as wheelchairs or crutches, when supplied by a hospital or surgical center and related to a client's inpatient or outpatient care, and billed with a charge of $250 or more will be reimbursed at invoice cost plus an additional charge of no more than 50%. Verification of invoice cost must be attached to the bill when it is submitted for payment.

Use of state consultant

If RS staff encounter difficulties in getting access to needed services for VR clients, or if staff need assistance in negotiating reasonable fees for specific services, they may contact the State Medical Consultant for assistance.

Exceptions to hospital discount rate schedule

Before exceptions are allowed, staff must first seek assistance in negotiating from the State Medical Consultant. Such negotiations may form the basis for the RS Manager or Regional Program Administrator's decision to approve or deny requests for exceptions to this policy. Each RS Program Administrator will establish a procedure for routing such exception requests through the RS Managers, RS Program Administrator or both. Use of the Exceptions Request Form (see Forms Part 54) is required.

Anesthesia and other related expenses

When including surgery as an IPE service, the counselor must analyze and document the follow factors:

- Prognosis and doctor's written recommendation.

- Medical necessity.
- Analysis of how the surgery will correct, stabilize, or reduce the progression of the disabling condition, if appropriate.
- Client's willingness to adhere to lifestyle changes, as appropriate, before and after surgery.
- Client's prior efforts to resolve the issue using alternatives to surgery, if such alternatives are available and medically feasible.
- Availability and application of comparable benefits (unless the client requires the service immediately because of extreme medical rush.)
- Analysis of how/why the surgery is required to reduce or minimize an impediment to employment and the impact of this service on the client's ability to achieve employment.
- Analysis of whether there are feasible alternatives.

Surgery

Special conditions apply to the provision of surgery. See Section 4 / Part 11.

Section 4 Medical Services

Part 10 Medications

RS pays up to the usual and customary price.

Use of generic equivalents

Whenever possible, it is required that a generic equivalent be substituted for a more expensive brand name drug. The use of generic equivalent drugs is required unless the prescriber has written dispense as written or has signed the name on the dispense as written signature line. Clients should be advised to request generic prescriptions from their physicians.

Authorized prescription necessary

Any medications, including over-the-counter drugs, must be specifically prescribed by a health care provider in order to be paid for through VR funds.

Prior authorization required

Prior written approval must be obtained from the RS counselor before any medications will be paid for through VR funds. Such approval must be specific in identifying the medication and whether refills are authorized to be paid for through VR funds.

VR funding for co-pays

Funding of co-pays for medication is an allowable expense.

Exceptions

Exceptions may be approved by the RS Manager or RS Regional Program Administrator on an individual case basis. Each RS Program Administrator will establish a procedure for routing such exception requests through the RS Managers, RS Program Administrator or both. Use of the Exceptions Request Form (see Forms Part 54) is required.

Section 4 Medical Services

Part 11 Surgery

The spending authority for surgery/surgeries for the life of the case is $4,999.

When an individual surgery or a combination of surgeries is projected to cost $5,000 or more, prior approval is required by DCF purchasing. Use of the Exceptions Request Form (Forms Part 54) is required. These costs include hospital and primary doctor fees. These costs do not include radiology, anesthesia or other related expenses.

When including surgery as an IPE service, regardless of the projected costs, the counselor must analyze and document the following factors:

- Prognosis and doctor's written recommendation.
- Medical necessity.
- Analysis of whether there are feasible alternatives.
- Client's prior efforts to resolve the issue using alternatives to surgery, if such alternatives are available and medically feasible.
- Client's willingness to adhere to lifestyle changes, as appropriate, before and after surgery.
- Analysis of how the surgery will correct, stabilize, or reduce the progression of the disabling condition, if appropriate.
- Analysis of how/why the surgery is required to reduce or minimize an impediment to employment and the impact of this service on the client's ability to achieve employment.
- Availability and application of comparable benefits (unless the client requires the service immediately because of extreme medical risk.)

Appropriate CPT and service codes are required.

Special procedures for dental surgery:

- The surgery analysis described above is required for oral and maxillofacial surgeries with American Dental Association (ADA) procedure codes D7260 to D7999.

- The surgery analysis is NOT required for ADA procedure codes D7000 to D7259. Therefore, most extractions will not require completion of the surgery analysis.
- The Counselor must get the ADA code from the dentist prior to authorizing the service in order to determine whether the surgery analysis is required.
- See Resources - Part 29 for a copy of the ADA code listing.