

PHYSICAL MEDICINE AND REHABILITATION SERVICE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive describes policy and procedures for the mission, purpose, organization, provision of standards of rehabilitative care, business practices, performance improvement strategies, and responsibilities regarding physical medicine and rehabilitation programs and services.

2. SUMMARY OF CONTENT:

a. Amendment dated April 4, 2022, incorporates current VHA policy on collecting outcomes associated with inpatient rehabilitation, eliminating the mandate to use the Functional Independence Measure (FIM™) by adding the option to utilize Section GG of the Inpatient Rehabilitation Facility (IRF) - Patient Assessment Instrument (PAI) to measure functional performance outcomes. **NOTE:** *This amendment incorporates policy on physical medicine and rehabilitation outcomes for inpatient rehabilitation units. VHA Directive 1225, Physical Medicine and Rehabilitation Outcomes for Inpatient Rehabilitation Units, dated February 8, 2017 is now rescinded via VHA Notice 2022-03, Rescission of VHA Directive 1225 Physical Medicine and Rehabilitation Outcomes for Inpatient Rehabilitation Units, dated March 25, 2022.*

b. As published November 5, 2019, this VHA directive replaced VHA Handbook 1170.03, Physical Medicine and Rehabilitation Services Procedures, dated May 2, 2014, and included directions from VHA Handbook 1170.04, Rehabilitation Continuum of Care, dated December 30, 2014, and VHA Directive 2012-016, Documentation of Kinesiotherapy Services in Department of Veterans Affairs Community Living Centers in the Resident Assessment Instrument Minimum Data Set, dated May 9, 2012. This directive updated procedures and requirements for comprehensive continuum of rehabilitation care provided to Veterans with disabilities and injuries. This directive also updated direct scheduling within rehabilitation services.

c. **RELATED ISSUES:** VHA Handbook 1170.02, Audiology and Speech-Language Pathology Services, dated December 9, 2020, and VHA Directive 1172.01, Polytrauma System of Care, dated January 29, 2019.

d. **RESPONSIBLE OFFICE:** The Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services (12RPS) is responsible for the contents of this VHA Directive. Questions may be referred to the National Director, Physical Medicine and Rehabilitation Service (PM&RS), at VHA12RPSRehabandProstheticsAction@va.gov.

e. **RESCISSIONS:** VHA Handbook 1170.03, VHA Handbook 1170.04, and VHA Directive 2012-016 are rescinded. **NOTE:** *VHA Directive 1225, Physical Medicine and Rehabilitation Outcomes for Inpatient Rehabilitation Units, dated February 8, 2017 is*

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rescinded by, VHA Notice 2022-03, Rescission of VHA Directive 1225 Physical Medicine and Rehabilitation Outcomes for Inpatient Rehabilitation Units, *dated March 25, 2022.*

f. **RECERTIFICATION.** This VHA directive is scheduled for recertification on or before the last working day of November 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY THE DIRECTION OF THE UNDER
SECRETARY FOR HEALTH:**

/s/ Lucille B. Beck, PhD.
Deputy Under Secretary for
Health for Policy and Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on November 6, 2019.

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PHYSICAL MEDICINE AND REHABILITATION SERVICE

1. PURPOSE

This Veterans Health Administration (VHA) directive describes the Physical Medicine and Rehabilitation Service (PM&RS). PM&RS assists VA medical facility leadership in establishing, administering, maintaining, and improving programs provided to Veterans with disabilities and injuries. This VHA directive also describes an approach that integrates rehabilitative service procedures across VHA's continuum of health care services. Changes in VHA process described in this directive reflect innovations and efforts to standardize the provision of rehabilitative care. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1706(b), 1710, 1710(A), 1782, and 7301(b).

2. BACKGROUND

a. **PM&RS Mission.** The three-fold mission of PM&RS is:

(1) To provide comprehensive rehabilitation of the Veteran and caregiver across a full continuum of care. Utilizing an interdisciplinary team approach, PM&RS develops and implements an individualized plan of care for each Veteran to prevent, manage, or limit impairments and disabilities of individual patients, while improving the patient's functional abilities, independence, and quality of life. The standard of care must be continually monitored and delivered according to best practices and clinical practice guidelines available in the academic and private sectors of health care. In accordance with 38 U.S.C. 1706(b), PM&RS is required to provide specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness); and to provide these services in consultation with recommendations of the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(2) To commit to the education and training of rehabilitation professionals necessary to deliver all required rehabilitation functions to support patient care. PM&RS cooperates with all appropriate educational offices at VA Central Office, Veterans Integrated Service Network (VISN) sites, and local VA medical facilities in the identification and provision of training activities to meet the needs of all rehabilitation personnel.

(3) To support the Office of Research and Development (ORD), particularly the Rehabilitation Research and Development (RR&D) Service, in promoting clinical and scientific research directed toward the advancement of the art and the science of medical rehabilitation and engineering technology.

b. **PM&RS Scope.** PM&RS utilizes diagnosis, treatment, and prevention methodologies. Interdisciplinary care emphasizes the evaluation, restoration, and optimization of function through physical modalities, therapeutic exercise and interventions, pain management, adaptive equipment, modification of the environment,

education and consultation, and assistive devices to prepare for the Veteran's optimum highest functional level of independence and also improving quality of life for both Veteran and caregiver. Scope also include prescription authority for those practitioners who are credentialed or privileged with such. **NOTE:** *Prescription authority is not covered in this policy, see VHA Directive 2009-035 Pain Management, dated October 28, 2009 for more information.*

c. **PM&RS Population.** PM&RS serves young adult to geriatric Veterans, with a wide spectrum of neurological, orthopedic, medical, psychiatric, and surgical conditions, including special populations with stroke, spinal cord injury (spinal cord injury and disorder (SCI/D) that are not served by the SCI/D System of Care), dementia, brain dysfunction or traumatic brain injury (TBI), and amputation. PM&RS is committed to providing specialized treatment and excellence in rehabilitation care across the full continuum of care to all Veterans with disabilities, injuries or impairments. **NOTE:** *For more information about spinal cord injury and disorder (SCI/D) that are served by the SCI/D System of Care, see VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, dated September 30, 2019.*

d. **PM&RS Organizational Structures.** The organizational structure of PM&RS varies between VA medical facilities. Core rehabilitation services typically include: physiatry, physical therapy (PT), occupational therapy (OT), kinesiotherapy (KT), recreation therapy (RT), speech language pathology (SLP) and vocational rehabilitation specialists. **NOTE:** *All of these disciplines may not be available at all VA medical facilities.*

e. **Rehabilitation Outcomes.** The Centers for Medicare & Medicaid Services (CMS) announced in 2018 they were removing Functional Independence Measure (FIM™) Instrument and Associated Function Modifiers from the Inpatient Rehabilitation Facility (IRF) - Patient Assessment Instrument (PAI) and transitioning to section GG of the IRF PAI to measure functional performance. VA has rescinded VHA Directive 1225 to remove the requirement to use FIM™ to monitor outcomes during inpatient rehabilitation.

3. DEFINITIONS

a. **Activities of Daily Living.** Activities of daily living (ADL) are daily self-care activities. Health professionals routinely monitor the ability or inability to perform ADLs using the Functional Independence Measure (FIM™) or section GG of the Inpatient Rehabilitation Facility (IRF) - Patient Assessment Instrument (PAI).

b. **Functional Related Groups.** Functional related groups (FRGs) are a classification system that stratifies Veterans by severity of impairment and are used for facility planning, research on outcomes, and determining costs of rehabilitation. FRGs are based on four predictor variables:

- (1) Diagnosis leading to disability;
- (2) FIM™ admission motor score;

- (3) FIM™ admission cognitive score; and
- (4) Veteran age.

c. **Instrumental Activities of Daily Living.** Instrumental activities of daily living (IADL) are more complex tasks than the daily self-care activities that are not necessary for fundamental functioning, but they allow an individual to maintain independence in the home and community; including:

- (1) Ability to manage finances;
- (2) Ability to use the telephone;
- (3) Assistance with transportation;
- (4) Housekeeping and cleaning rooms;
- (5) Laundry;
- (6) Meal preparation;
- (7) Obtaining appointments;
- (8) Shopping- for groceries or clothing;
- (9) Taking medications; and
- (10) Writing letters or other electronic communications.

d. **Interdisciplinary Rehabilitation Plan of Care.** The interdisciplinary rehabilitation plan of care is a Veteran-centered plan of care created by the Interdisciplinary Team (IDT). To create this plan, each member of the IDT recommends Veteran-specific goals and interventions as a result of their assessments. These treatment plans are intended to be dynamic documents changing in response to the Veteran's condition and progress toward goals.

f. **Resident Assessment Instrument Minimum Data Set.** Resident assessment instrument (RAI) minimum data set (MDS) is a standardized methodology for assessment and treatment planning that was developed by the Centers for Medicare and Medicaid Services (CMS), and is used to assess residents in long-term care settings. VHA adopted its use in 2000. MDS is utilized to assess and collect a standardized set of physical, psychological, and psychosocial functioning data on all Veterans in a long-term care facility in the U.S., including VHA.

g. **Restorative Care.** Restorative care is a nursing service in collaboration with rehabilitation services, consisting of interventions and programs that focus on Veterans who have become deconditioned due to acute illness, or chronic debilitating disease, or prolonged inactivity. A focused program of restorative care involves planned

interdisciplinary interventions to improve the Veteran's functional status; it facilitates transition to home or a less restrictive level of care. Restorative care is provided primarily in CLC by nursing staff, in collaboration with therapy services staff who may serve as consultants.

h. **Skilled Therapy.** Skilled therapy involves complex and sophisticated therapy procedures requiring the judgment and skill of a qualified rehabilitation therapist (i.e. PT, KT, OT, or SLP). Veterans receiving skilled therapies have individualized goals for functional improvement. Skilled therapy does not include services for skill maintenance or services provided in a restorative nursing care program. A skilled therapist may participate in establishing a plan of care or restorative therapy goal, but does not actually participate in maintenance or restorative care programs.

4. POLICY

It is VHA policy that all Veterans eligible for VA services and active duty Servicemembers covered by the Military Health Care System (TRICARE) authorization as determined by the VHA Office of Community Care have access to a clinically appropriate level of rehabilitative services across the continuum of care. **NOTE:** *Provision of standardized rehabilitative services includes but is not limited to access to contractual arrangements and individualized care, enables continued readiness and advancement in the delivery of physical medicine and rehabilitation services to Veterans within VHA.*

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the VISN.

(2) Ensuring that each VISN Director has sufficient resources to implement this directive in all VA medical facilities within that VISN; and

(3) Providing oversight of VISNs to ensure compliance with this directive.

c. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for:

(1) Communicating the contents of this directive throughout the office of the Deputy Under Secretary for Health for Policy and Services.

(2) Ensuring support and resources to comply with this directive.

(3) Providing clinical programmatic oversight to ensure compliance with this directive.

d. **Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services.** The Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services is responsible for:

(1) Ensuring support to comply with this directive.

(2) Reviewing and collaborating with the National Director, PM&RS on proposed changes to PM&RS policies including: VHA Directive 1125, Driver Rehabilitation Program Report (RSC 10-0099), dated July 9, 2015; VHA Directive 1173.16, Driver Rehabilitation for Veterans with Disabilities Program, dated November 28, 2017; VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019; VHA Directive 1172.03, Amputation System of Care, dated August 3, 2018; VHA Directive 1040, Water Safety Certification Requirements for Therapeutic and Recreational Swimming Pool Staff, dated May 4, 2020; and VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans, dated April 6, 2017. **NOTE:** *The Deputy Chief may only suggest changes and must coordinate with the Office of Regulatory and Administrative Affairs regarding amendments and recertifications to national policy.*

(3) Communicating programmatic changes to PM&RS to the Deputy Under Secretary for Health for Policy and Services.

(4) Ensuring that accreditation is earned by coordinating with the accrediting officials.

e. **National Director, Physical Medicine and Rehabilitation Service.** The National Director, PM&RS, is responsible for:

(1) Ensuring that rehabilitation policy, procedures, and programmatic standards of care are developed and maintained for PM&RS.

(2) Providing operational consultation and guidance upon request to VISNs and VA medical facilities for the development and operation of PM&RS.

(3) Reviewing and approving all PM&RS program change requests including waiver for bed units, and providing recommendations to program, VA medical facility, VISN, and VHA leadership. **NOTE:** *For more information on bed change requests, see VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010.*

(4) Responding to inquiries from internal and external stakeholders about PM&RS and operations.

f. **Veterans Integrated Service Network Director.** Each Veterans Integrated Service Network (VISN) Director is responsible for:

(1) Ensuring that PM&RS are accessible to eligible Veterans and Active Duty Servicemembers covered by the Military Health Care System (TRICARE) authorization as determined by the VHA Office of Community Care. The entire rehabilitation continuum of care and clinical services may not be present in a single VA medical facility but must be available to all Veterans treated within a VISN.

(2) Ensuring that programs are operated in compliance with this VHA directive.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Implementing and maintaining the appropriate staffing and clinical expertise, to provide rehabilitation services within the VA medical facility.

(2) Having final authority over, and responsibility for, the accountability of the rehabilitation program within the organizational structure.

(3) Removing barriers to people with disabilities in accordance with the Americans with Disabilities Act (ADA) of 1990 and ADA Amendments Act of 2008 (42 U.S.C.126).

NOTE: The VA medical facilities structures, especially clinics within PM&RS, must meet ADA requirements and all VA employees must complete Ethics and Diversity Training.

(4) Supporting public information efforts designed to inform various groups about the benefits of physical medicine and physical rehabilitation and supporting physical rehabilitation in-service and educational programs.

(5) Ensuring that no proposed organizational change in a rehabilitation bed unit is implemented without prior approval of the National Director of PM&RS. ***NOTE: For additional information see VHA Handbook 1000.01.***

(6) Collaborating with VA medical facility PM&RS Chief or Service Line manager and Human Resources Management, to determine the most appropriate supervision and leadership of therapy disciplines. ***NOTE: In larger programs, it is appropriate for each therapy discipline to have their own specific therapy supervisor or lead. In VA medical facilities that have service line organization, therapies may be supervised by a program or clinical manager.***

(7) Ensuring that PM&RS is represented with at least one member on VA medical facility-wide committees in order to promote the needs of disabled Veterans.

h. **Physical Medicine and Rehabilitation Service, Chief or Service Line Manager.** The Chief, PM&RS or Service Line manager is responsible for:

(1) Having a working knowledge of the principles of interdisciplinary rehabilitation to communicate pertinent Veteran care and service delivery issues to senior VA medical facility leadership, national program office, and local PM&RS staff.

(2) Ensuring the development and accomplishment of annual PM&RS strategic service delivery plans.

(3) Maintaining compliance with programmatic standards established within this policy and local procedures, maintain continued readiness and enhance service delivery.

(4) Gathering stakeholder feedback and input from all levels of personnel for decision making and for enhancements in service delivery and staff engagement.

(5) Establishing a lead or senior therapist, in those instances when a therapy discipline for PT, KT and OT is not supervised by a person credentialed in that therapy discipline. This lead or senior therapist must be the subject matter expert for that discipline in areas such as: recruitment, performance evaluation, training, competencies, scope of practice, and other professional discipline issues.

(6) Ensuring employee engagement across the rehabilitation team by sharing best practices, staff development opportunities including professional training programs, encouraging continuing education, and providing rewards and recognition.

(7) Recommending to VA medical facility director projected staffing needs, equipment and supply management, and other operational aspects of administering and managing a program. **NOTE:** *Any such recommendations are based on information and data PM&RS facility staff has collected and analyzed.*

(8) Supporting local and community public awareness efforts designed to inform stakeholders regarding the benefits of rehabilitation, including presenting rehabilitation in-services and educational programs.

(9) Ensuring appropriate PM&RS orientation is provided to all Veterans admitted to the inpatient rehabilitation unit, as well as to the Veterans' family members and caregivers. **NOTE:** *It is strongly recommended that a rehabilitation orientation packet be given to each Veteran upon admission. If the unit is Commission on Accreditation of Rehabilitation Facilities (CARF) accredited, the orientation must include what services the Veteran will receive and predicted outcomes.*

(10) Managing information, monitoring outcomes (e.g. Veteran access, quality indicators, workload, staff productivity, clinic capacity and utilization), and performance improvement. This includes establishing procedures on how the program obtains and uses Veteran outcome data and information to continually improve the quality of care to Veterans and their families.

(11) Overseeing the care rendered by rehabilitation specialists, as defined by the discipline scope of practice, individual staff competency, and VA medical facility-level

procedures. **NOTE:** *There are standards for all Hybrid Title 38 professions which include: PT, OT, KT, Physical Therapy Assistant (PTA), and Occupational Therapy Assistant (OTA). These standards must be considered when hiring or promoting a professional in each of these occupations.*

(12) Maintaining regular contact with and disseminating information from the National PM&RS Program Office to all local rehabilitation personnel at their VA medical facility.

i. **Interdisciplinary Team.** Disciplines represented on the rehabilitation IDT may include, but are not limited to: psychiatry, Geriatric and Extended Care (GEC) medical provider, primary care provider and VA patient aligned care team (PACT), rehabilitation nursing, occupational therapy (OT), physical therapy (PT), kinesiotherapy (KT), recreational therapy (RT), speech language pathology (SLP), psychology, audiology, optometry, ophthalmology, clinical pharmacy specialist, social work, and nutrition. Other disciplines, may be consulted as determined by the Veteran's needs. The interdisciplinary team (IDT) is the hallmark of rehabilitation care. The IDT is responsible for:

(1) Collaborating with all the disciplines specialized in the evaluation and management of complex needs of Veterans who would benefit from comprehensive and intensive rehabilitation services.

(2) Developing an individualized rehabilitation treatment plan with goals and timeframes established, and clinical outcomes are monitored on a routine basis.

(3) Ensuring the Veteran and their family are integrated into the IDT.

j. **PM&RS Rehabilitation Therapists.** Skilled rehabilitation specialists within PM&RS, to include KTs, OTs, and PTs, are responsible for:

(1) Performing their profession within the limits of their academic preparation and approved scope of practice. **NOTE:** *Scopes of practice are established by each discipline's professional organization and the professional organization ensures that the therapy practitioner meets the standards for education, credentialing, and professional competence. For more information see VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, and VHA Directive 1100.20, Credentialing of Health Care Professionals, dated September 15, 2021.*

(2) Maintaining the licensure, certification and/or registration credential in accordance with VHA Handbook 1100.19 and VHA Directive 2012-030.

6. PHYSICAL MEDICINE AND REHABILITATION SERVICES

a. Veterans throughout the continuum of care may demonstrate a need for rehabilitation services to improve their functional status. Referrals to PM&RS originate through an electronic consult from multiple sources throughout the continuum of care.

NOTE: *See Appendix A for details about the continuum of care.*

b. In some instances, such as in physical therapy, amputation and wheeled mobility clinics, the Veteran can use patient self-referral direct schedule (PSDS) and be seen without any additional consultative action unless the therapist determines it is necessary for the Veteran's physician to provide medical clearance prior to proceeding with therapy evaluation. Additional examples of walk-in clinics include, but are not limited to, issuing durable medical equipment (DME), canes, crutches, walkers, health coaching, and pre-operative instructions.

c. All referrals for admission for acute inpatient rehabilitation services or Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP), a designated person such as a nurse manager, case manager, physician, rehabilitation therapist or social worker needs to coordinate the admission with the referral source, the Veteran, caregiver, the Veteran's family, and the rehabilitation IDT.

d. Regardless of the origin of the rehabilitation referral, once a consult to a rehabilitation program is initiated, the Veteran must be screened by the IDT for an appropriate rehabilitation treatment plan of care based on the Veteran's rehabilitation needs within the facility's procedures.

e. PM&RS providers must monitor the quality of the services and treatment programs through the analysis of individual and aggregate clinical outcomes. **NOTE:** *CARF standards require monitoring quality indicators to measure service effectiveness. It is strongly recommended, that CIIRP units analyze access, patient flow and utilization data as well as functional gains. CARF standards encourage CIIRP units to have a culture for performance improvement process in place on the rehabilitation unit.*

7. TRAINING

There are no formal training requirements associated with this directive.

8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

9. REFERENCES

a. Pub. L. 110-181.

b. 38 U.S.C. 1706(b); 1710, 1710A, 1710B, 1782, and 7301(b).

c. 42 U.S.C.126.

d. VHA Directive 1040, Water Safety Certification Requirements for Therapeutic and Recreational Swimming Pool Staff, dated May 4, 2020.

e. VHA Directive 1125, Driver Rehabilitation Program Report (RSC 10-0099), dated July 9, 2015.

f. VHA Directive 1149, Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers, dated June 1, 2017.

g. VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated May 9, 2017.

h. VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019.

i. VHA Directive 1172.03, Amputation System of Care, dated August 3, 2018.

j. VHA Directive 1173.16, Driver Rehabilitation for Veterans with Disabilities Program, dated November 28, 2017.

k. VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, dated September 30, 2019.

l. VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans, dated April 6, 2017.

m. VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021

n. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.
NOTE: *The Credentialing portion of this handbook has been superseded by VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.*

o. VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010.

p. VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC), dated August 13, 2008.

q. VHA Handbook 1142.03, Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), dated January 4, 2013.

r. VHA Handbook 1170.02, Audiology and Speech-Language Pathology, dated December 9, 2020.

s. American Kinesiotherapy Association (AKTA): <https://akta.org/wp-content/uploads/2018/01/Scope-Of-Practice-revised-Jan-2018-Final.pdf>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

t. American Occupational Therapy Association's (AOTA): <https://www.aota.org/>.
NOTE: *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

u. American Physical Therapy Association's (APTA):
<http://www.apta.org/ScopeOfPractice/>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

v. Claims and Reimbursement for Therapy Services. Chapter 7:
https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. **NOTE:** *This is an internal VA Web site that is not available to the public.*

w. Joint Commission Homecare Standards and Durable Medical Equipment (DME) Home Care Standards

x. Memorandum of Understanding Between the Department of Veterans Affairs and Department of Defense For Interagency Complex Care Coordination Requirements for Service Members and Veterans: <https://health.mil/Reference-Center/Policies/2014/07/25/MOU-for-Interagency-Complex-Care-Coordination-Requirements-between-VA-and-DoD>. **NOTE:** *This Web site is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

y. Minimum Data Set (MDS) Generated Rehabilitation Resource Utilization Groups (IV). PM&RS SharePoint:
<https://vaww.infoshare.va.gov/sites/rehab/pmrs/PMRS%20Policies/Forms/AllItems.aspx?RootFolder=%2Fsites%2Frehab%2Fpmrs%2FPMRS%20Policies%2FPMRS%20Directives&FolderCTID=0x012000BAE8604B49079A4BAE1C57EA20C65271&View=%7B08BC1029%2D1375%2D4476%2DBFB7%2DDCD8E4935DB6%7D>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

z. PM&RS Therapy and Rehabilitation Services. Chapter 7, Section C:
https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. **NOTE:** *This is an internal VA Web site that is not available to the public.*

aa. Occupational Therapy Practice Framework: Domain and Process. American Journal of Occupational Therapy. November 2002, Vol. 56, 609-639:
<https://ajot.aota.org/article.aspx?articleid=1869228>. **NOTE:** *This Web site is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

bb. Telerehabilitation. <http://vaww.telehealth.va.gov/clinic/rehab/trehb/index.asp>.
NOTE: *This is an internal VA Web site that is not available to the public.*

cc. Uniform Data System for Medical Rehabilitation: www.udsmr.org. Accessed January 1, 2019. **NOTE:** *This Web site is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

dd. VHA Community Care Knowledge Base Navigation Portal. Chapter 6 Section A: Kinesiotherapy Coverage and Billing Requirements: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050097/Section-A-Kinesiotherapy-Coverage-and-Billing-Requirements. **NOTE:** *This is an internal VA Web site that is not available to the public.*

ee. VHA Office of Quality, Safety and Value, Division of External Accreditation Services & Programs: <http://vaww.oqsv.med.va.gov/functions/integrity/accr/carfAccrProgs.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public*

VHA REHABILITATION CONTINUUM OF CARE STANDARDS

1. REHABILITATION CONTINUUM OF CARE

Rehabilitation occurs across a continuum at various levels of intensity and in different care settings. Veterans may have their rehabilitation provided in a variety of environments from acute inpatient hospitalization, through a spectrum of inpatient and outpatient rehabilitation care settings, including Community Living Centers (CLCs), and within the home, if medically appropriate. For rehabilitation designated inpatient rehabilitation unit must earn and maintain Commission on Accreditation for Rehabilitation Facilities (CARF) Accreditation. **NOTE:** *The National Director Physical Medicine and Rehabilitation Services (PM&RS) Program may approve a waiver for smaller bed units by issuing a memorandum through the VA medical facility director and Veterans Integrated Service Network (VISN) director.* A list of CARF-accredited programs is provided for reference by VHA Office of Quality, Safety and Value, Division of External Accreditation Services & Programs:

<http://vaww.oqsv.med.va.gov/functions/integrity/accred/carfAccrProgs.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

2. CORE LEVELS OF CARE

a. The continuum of rehabilitation services provided to the Veteran is determined by the Veteran's rehabilitative needs and not by the rehabilitation unit location or designation.

b. Core levels of care in the rehabilitation continuum include:

(1) **Acute Medical Rehabilitation Consultative Services.**

(a) Hospitalized Veterans experiencing the onset of illness or injury may benefit from one or more rehabilitation therapies to assist in regaining physical and functional abilities.

(b) To initiate access to acute medical rehabilitation consultative services, an appropriate credentialed and privileged provider or advanced practice provider with an approved scope of practice initiates this consult to PM&RS for a comprehensive medical assessment or to manage a specific condition, such as Polytrauma, Traumatic Brain Injury (TBI), or amputation care, or to perform or recommend various modalities and therapy treatments. **NOTE:** *In most Department of Veterans Affairs (VA) medical facilities, Nurse Practitioners (NPs) and Physician Assistants (PAs) are able to initiate consults and make referrals for specific therapies such as occupational therapy (OT), physical therapy (PT), kinesiotherapy (KT), recreational therapy (RT) and speech-language pathology (SLP) specialists, if their approved scope of practice at the VA medical facility permits.*

(c) These services are provided in central therapy clinics, satellite clinics, and at the bedside or in another environment (e.g. home, group home, and assisted living facility) depending upon the needs of the Veteran.

(2) Comprehensive Integrated Inpatient Rehabilitation Program.

(a) Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) (i.e. Inpatient Rehabilitation Bed Services) provides a Veteran-centered, coordinated, intensive program of integrated medical and rehabilitation services delivered by the rehabilitation interdisciplinary team (IDT) that may include, but is not limited to: psychiatry, rehabilitation nursing, rehabilitation case management, OT, PT, KT, SLP, RT, social work, and psychology. The IDT supports and reinforces each Veteran's individual plan of care 24 hours a day, 7 days a week for those medically stable who require and are able to tolerate intensive rehabilitation services. Intensity and duration of therapy is individualized to the needs of the Veteran, but often include 2 to 3 or more hours of treatment comprised of two or more rehabilitation goal-oriented therapies per day (e.g. OT, PT, KT, SLP and RT). **NOTE:** *For more information see VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated May 9, 2017.*

(b) CIIRP must meet high standards of care and earn accreditation from CARF. Regardless of the location, if an inpatient bed section's function is designated as comprehensive inpatient rehabilitation it is recommended to be accredited by CARF. The PM&RS Chief or designee ensures that accreditation is earned by coordinating with the accrediting officials. **NOTE:** *CIIRP units must meet CARF standards in order to be called CIIRP units. There are no waivers for VA medical facilities who do not receive CARF accreditation.*

(c) Rehabilitation beds must be co-located in the same designated area, and treatment areas must provide opportunities for Veterans to interact with each other as part of the rehabilitation process. The physical location of inpatient rehabilitation beds varies. Rehabilitation bed units may be in their own designated area or may be located adjacent to acute medical services, such as neurology and general medicine. Rehabilitation beds may also be located in a designated area of the CLC.

(d) The focus of the CIIRP is on meaningful functional improvement and successful community re-entry. Goals are identified by the IDT and Veteran in mobility, activities of daily living (ADL), instrumental activities of daily living (IADL), productive activity, and preparation for home and community. The treatment program has a specific timeframe determined by the IDT's assessments and is goal-oriented with a focus on practical life-skills training. Treatment interventions are individualized incorporating Veteran and caregiver education and preparation for the Veteran's transition back into the community. Veterans remain in the CIIRP until goals are met, maximal functional improvement is achieved or it is determined by the IDT that the needs of the Veteran would be better served within another continuum.

(e) Each CIIRP program has admission criteria and an admission screening process. This level of care is appropriate for Veterans with one or more conditions requiring treatment by a rehabilitation team, at a level of intensity that can be provided more effectively and efficiently within an inpatient rehabilitation program. **NOTE:** *Admission criteria is determined within local procedures by the PM&RS Chief or designee. Veterans are admitted from various sources, including the same VA medical facility, another VA medical facility, military treatment facilities (MTF), community care, and home. NOTE: Some programs may offer short-stay evaluations to determine ongoing care needs, but this is not a requirement.*

(f) The Rehabilitation Continuum of Care Chart of Recommendations describes programming for specific rehabilitation services across the continuum of care (see Appendix C).

(3) **Outpatient Medical Rehabilitation.**

(a) Outpatient rehabilitation must be considered when a Veteran has functional limitations requiring skilled intervention by rehabilitation therapists, but inpatient medical care is not necessary. The expectation is that the Veteran's condition will improve in a reasonable and generally predictable period of time, or the services provided in outpatient rehabilitation are necessary for improving quality of life or establishing a safe and effective environment. Outpatient services may be provided in the outpatient therapy department, the community, or the home. A plan of care must be developed by the single therapy discipline or IDT in conjunction with the Veteran's medical or primary care team, either in the community or through the VA Patient-Aligned Care Team (PACT).

(b) Referrals for outpatient rehabilitation services are generated by various sources, e.g., primary care; medical subspecialties such as orthopedics, rheumatology, and neurology; inpatient attending physicians; and VA community providers with approved credentials and privileges or advanced practice providers according to a therapy discipline's scope of practice.

1. Within certain practice settings, Veterans may have direct access to physical therapy services without a physician's consult in accordance with state licensure; see the American Physical Therapy Association Web site for language regarding direct access at: <http://www.apta.org>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

2. The health care provider of record is sufficient to meet the needs of some of the states that have limited Direct Access or requirements to notify the health care provider.

(c) Following the initial therapy or IDT assessment, the Veteran will be scheduled for outpatient treatment at an established frequency and for an established duration. The assessing rehabilitation provider must have a reasonable expectation that the Veteran will improve from therapeutic intervention and that the Veteran is willing and able to participate in a rehabilitation program. When a response to treatment is not predictable,

a trial of rehabilitation therapy may be recommended by the rehabilitation provider who performed the evaluation.

(d) During the course of outpatient care, rehabilitation specialists may determine that additional services are needed, such as psychological, psychiatric, psychopharmacological, or other medical subspecialty consultation (for example, clinical pharmacology to consult on medication options for care or social work). Each VA medical facility must have a process to request additional services. **NOTE:** *Local procedures will outline service agreements and specific criteria for requesting outpatient rehabilitation consults for services.*

(4) Transitional Rehabilitation.

(a) Transitional rehabilitation is for Veterans and active duty Servicemembers covered by Defense Health Agency Great Lakes (DHA-GL) or TRICARE authorization with Polytrauma or TBI who have physical, cognitive, or behavioral difficulties that persist after the acute phase of rehabilitation and prevent such Veterans and Servicemembers from effectively re-integrating into the community or returning to duty.

(b) Transitional rehabilitation offers a progressive return to independent living through a structured program focused on restoring home, community, leisure, psychosocial, and vocational skills in a controlled, therapeutic setting. For more information about Transitional rehabilitation, Polytrauma or TBI, see VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019. **NOTE:** *There is a Memorandum of Agreement between VA and DHA which allows for active duty Servicemembers to be covered. For more information, see Memorandum of Agreement between Department of Veterans Affairs and Department of Defense for Medical Treatment Provided to Active Duty Servicemembers with Spinal Cord Injury, Traumatic Brain Injury, Blindness or Polytraumatic Injuries available at: <http://vawww.dodcoordination.va.gov/docs/MOAMOUSpinalCordInjuryTraumaticBrainInjury2.pdf>. **NOTE:** This is an internal VA Web site that is not available to the public.*

(5) Post-Acute Care/Community Living Center.

Rehabilitation services provided in a CLC (post-acute care) setting can vary in the intensity of services provided based on the needs of the Veteran and are indicated by Treating Specialty Code 64 designated for short-stay PM&RS Bed Sections. **NOTE:** *Treating Specialty Code 64 only applies to short-term rehabilitation admissions in the CLC. The CLC is considered post-acute care.*

(6) Home Based Primary Care.

Rehabilitation services may be provided as part of a home care program. Therapists providing services in the home setting must have specialized training to meet The Joint Commission Homecare Standards and Durable Medical Equipment (DME) Home Care Standards. **NOTE:** *The service chief or service care line manager or designee is responsible for maintaining rehabilitation services staff competency and training. For*

Home Based Primary Care supervisors will also need to coordinate and ensure all IDT members are educated on The Joint Commission standards.

(7) Telerehabilitation and Virtual Rehabilitation Care.

(a) Telerehabilitation services can be used to increase access to specialty rehabilitation care on an outpatient basis. These services allow the provider to be located at a tertiary VA medical facility while the Veteran is at a Community-based Outpatient Clinic or at home. **NOTE:** *For more information on Telerehabilitation, see: <http://vaww.telehealth.va.gov/clinic/rehab/trehb/index.asp>. This is an internal VA Web site that is not available to the public.*

(b) Veterans with disabilities, especially in rural areas, can greatly benefit from telerehabilitation. Many of these Veterans have mobility issues or socioeconomic factors that affect their ability to receive needed care. The results are that this population often have decreased access to care and possibly decreased quality of care. For Veterans with disabilities that need long-term follow-up, such as stroke or TBI, telerehabilitation offers the option for health care providers to enhance services that can be offered, thereby assisting in increased functional gains and social re-integration.

INTERDISCIPLINARY REHABILITATION TEAM PROCEDURES

1. ASSESSMENT PROCESS AND DOCUMENTATION

a. A thorough initial assessment is performed by all members of the interdisciplinary rehabilitation team. This assessment gathers pathophysiological, functional, cognitive, communicative, behavioral and emotional, pharmacological, physical, and social data regarding each Veteran's goals, impairments, activity limitations, participation restrictions, discharge environment, and need for care. This data is analyzed to:

(1) Gather the information necessary to decide the approach and timeframes to meet the Veteran's rehabilitation care needs; and

(2) Enable the interdisciplinary team (IDT) to establish the Veteran's plan of care. Evaluation and treatment are initiated according to the timeframe established in the VA medical facility's PM&RS procedures.

b. **Interdisciplinary Rehabilitation Team.** Rehabilitation care is Veteran-centered. The Veteran is a crucial member of the team whose goals must be at the center of the rehabilitation process. In addition to the Veteran, members of the IDT may include an attending Physician/Physiatrist, Physical Therapist, Occupational Therapist, Kinesiotherapist, Recreational Therapist, Speech and Language Pathologist, Rehabilitation Nursing, Case Manager, Social Worker, Clinical Pharmacy Specialist, Psychologist, and the Veteran's family or significant other. Consultants to the IDT consists of the following members including but not limited to an Audiologist, Blind Rehabilitation Staff, a Chaplain, a Dietitian, an Optometrist, a Podiatrist, a Prosthetist or an Orthotist, a Respiratory Therapist, Medical, Surgical, and Psychiatric Specialists, a Wound Care Specialist, Peer Support Groups, an Educator, a Women's Veteran Program Manager or Women's Health Team Case Manager.

2. INTERDISCIPLINARY PLAN OF CARE

a. The IDT compiles the assessment information from all IDT members into a single custom plan of care for the Veteran for purposes of identifying individualized treatment goals and predicted outcomes. The plan of care represents the overall direction that the IDT is working towards assisting the Veteran to achieve improvements in independence, function, and quality of life. **NOTE:** *An interdisciplinary plan of care can be used for both inpatients and outpatients.*

b. Each member of the IDT administers discipline-specific evaluations based on the individual medical and surgical diagnoses, impairments, and sequelae of the Veteran. Based on these evaluations, the IDT establishes the projected achievable goals and timelines for rehabilitation. The physiatrist or physician with extensive rehabilitation experience provides oversight to the interdisciplinary rehabilitation plan of care. The interdisciplinary plan is recorded in the electronic health record (EHR). Any changes to the plan, made by either the IDT or the Veteran, are communicated to the

interdisciplinary team by updating the EHR. The physician designates a point of contact (POC) to communicate the IDT plan to the Veteran.

c. For the CLCs, the interdisciplinary plan of care and IDT meetings guide the clinical process for Veterans requiring intervention from the CLC IDT members. The core CLC members include the medical provider, registered nurse, nursing assistant, social worker, recreation therapist and registered dietitian. Rehabilitation professionals are an integral part of the CLC IDT as well. The rehabilitation plan of care will be integrated into the CLC plan of care which will provide one plan of care for the Veteran and the IDC to follow.

d. The interdisciplinary plan of care is a Veteran-centered, based on active involvement of the Veteran, family, and IDT members or other support system participants identified by the Veteran and IDT. The plan synthesizes information gathered from the Veteran, family, and discipline-specific evaluations, allowing for the completion of a functional impairment list, identified interventions, and expected short-term, long-term, and discharge goals. Based on input from the Veteran and the overall IDT assessment, the strengths, abilities, needs, and preferences of the Veteran are identified and noted in the plan of care. The interdisciplinary plan of care must include measurable goals, discharge planning, and patient education (e.g. patient safety concerns documentation). The IDT determines the frequency of treatment and the estimated length of stay at admission, which are reviewed with the Veteran. The interdisciplinary plan of care is not intended to replace discipline-specific treatment plans or notes. **NOTE:** For more information see *Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019.*

e. Regular and frequent assessments must be performed on a discipline-specific and interdisciplinary basis, including a revision of program goals and areas of identified need, as required by the Veteran's condition. These assessments include specific and detailed information regarding the progress of the individual as determined by the re-evaluations of each consulted discipline to ensure that appropriate adjustments are made to the plan of care, and facilitate discharge planning. The results of re-evaluations are documented in the EHR and communicated to the team and the Veteran during the IDT meeting. Assessment and re-assessment timeframes are determined within local medical facility procedures.

f. All IDT members must complete a discharge summary relevant to their discipline's scope of practice. The combined discharge summaries must detail the medical, physical, functional, cognitive, psychological, and psychosocial status of the Veteran at the time of discharge. The summary must include medications, activity restrictions, adaptive equipment provided, and progress towards rehabilitation goals. Additional discharge information states the discharge home environment, written instructions provided to the Veteran, caregiver, any community contacts, and future appointments to assist with the Veteran's transition back into the community.

g. For outpatient rehabilitation, the interdisciplinary plan of care and IDT meetings guide the clinical process for Veterans with functional rehabilitation goals requiring intervention from two or more rehabilitation professionals, if applicable. Outpatient rehabilitation IDTs are led by a board-certified or board-eligible attending physiatrist, physician with extensive rehabilitation experience, or resident physician. Outpatient rehabilitation IDTs provide individualized, coordinated, and outcome-focused outpatient services, including physiatry services, therapy services, education, and psychological treatment and support to Veterans who live in the IDT's local service area.

3. TREATMENT INTERVENTIONS

a. Provision of rehabilitation services and interventions is determined by an IDT with oversight by a board certified or board eligible attending physiatrist, physician with extensive rehabilitation experience, and resident physician (if on the team). Treatment interventions are an integration of medical, psychosocial, and functional interventions.

b. Veterans receiving comprehensive inpatient rehabilitation on a unit accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) receive services from the IDT, depending on the Veteran's assessed need. Rehabilitation care plans are communicated to the entire rehabilitation IDT, facilitated by the Rehabilitation Case Manager, and implemented on a continuous basis, 24-hours a-day, 7-days a-week.

4. REASSESSMENT AND MONITORING OF PROGRESS

a. The progress of each Veteran is reviewed regularly by the IDT with regard to:

(1) The response to the rehabilitation interventions as outlined in the interdisciplinary plan of care;

(2) Changes in the Veteran's condition;

(3) Choices for alternative interventions; and

(4) Progress towards meeting the rehabilitation goals.

b. The discharge plan is adjusted as necessary by the IDT.

c. The notes from IDT meetings need to address the progress made and specify any new or modified interventions needed prior to discharge. **NOTE:** *The first IDT meeting is with the Veteran and caregiver (if available) and any changes and recertification of the treatment plan will be communicated to the Veteran and caregiver (if available) thereafter.*

5. DOCUMENTATION

Progress reports are entered into the Veteran's EHR by each member of the IDT to reflect the Veteran's condition and progress towards the rehabilitation goals. Documentation frequency must meet the standard set in the Veterans Affairs (VA)

medical facility's Physical Medicine and Rehabilitation Services (PM&RS) procedures, which must be in accordance with the accrediting agency requirements for the VA medical facility.

6. VETERAN AND FAMILY EDUCATION

a. The Veteran and the Veteran's family are provided with appropriate education and training by IDT members as necessary throughout the rehabilitation process to become knowledgeable of the Veteran's condition and treatment needs, and learn skills and behaviors that promote the Veteran's recovery and improve function. **NOTE:** *Eligible individuals are also entitled to consultation, professional counseling, marriage and family counseling, training, and mental health service with the Veteran's treatment in accordance with 38 U.S.C. 1782.* Assessment of learning needs, abilities, and readiness to learn is done by each member of the rehabilitation team and documented in discipline-specific progress notes. **NOTE:** *Documentation of Veteran education may be documented by discipline-specific progress notes.*

b. Types of instruction include:

(1) Rehabilitation techniques to facilitate adaptation to, or functional independence in, the care environment including Community Living Center (CLC), Spinal Cord Injury (SCI), Polytrauma units, home care locations and community (e.g. curbs, ramps, uneven surfaces, gravel);

(2) Information about how to access available community resources;

(3) Safe and effective use of medical equipment, when applicable; and

(4) Safe and effective use of medication in accordance with legal requirements and the Veteran's needs.

7. THERAPEUTIC APARTMENT STAY OR THERAPEUTIC HOME PASS

The therapeutic apartment stay or home pass approved by the Veteran's provider is designed to help Veterans and their families evaluate the application of skills acquired in the inpatient rehabilitation program to their own home setting. A provider order stating the duration and approximate time for the Veteran to leave and return to the inpatient rehabilitation unit is required for a home pass. Information obtained as a result of an apartment stay or a home pass, needs to be communicated from the Veteran and/or family member and incorporated into the Veteran's treatment plan to maximize the Veteran's independence at home. For more information on authorized absences, passes, and campus privileges, see guidelines in Appendix A; and VHA Directive 1149, Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers, dated June 1, 2017.

8. FAMILY CONFERENCES

a. For the purpose of this directive, the family is defined as those persons living with the Veteran. In cases where the Veteran is living alone, family includes people identified by the Veteran to be contacted in case of emergency. The Veteran determines who is considered family, and who is appropriate to participate in the family conference, unless the Veteran lacks the mental capacity to make this determination. Family may include significant others, spouse, domestic partner, friend, children, siblings, or other blood relatives.

b. Family conferences organized by social work or case management are held at a frequency necessary to maintain effective and open communication. They usually occur near the time of admission and before discharge. In the family conference, information is exchanged by the IDT with the family and Veteran to reach an understanding of the rehabilitation plan. Additionally, education is provided regarding the Veteran's current status, progress, limitations, and prognosis. Questions are also answered, and effective discharge plans are confirmed.

c. After the completion of the family conference, a progress note is written and entered into the EHR by a designated IDT member outlining the purpose of the conference, the participants, and the outcome.

9. DISCHARGE

a. Discharge planning begins on the first day of admission (or prior to admission for Veterans seen on rehabilitation consult), and discharge action plans are reviewed during IDT meetings.

b. The estimated date of discharge and discharge action plans are set during the initial assessment and modified as needed by the IDT based on the Veteran's needs.

c. If discharge to the home setting is contemplated, appropriate arrangements to transition care to the outpatient primary care team must be initiated by social work and case management, with development of a care plan that builds upon rehabilitation progress in the inpatient setting.

d. Facilities must have processes in place for a Veteran and/or caregiver to appeal PM&R providers' medical decision that the Veteran is not a candidate or is no longer a candidate for rehabilitation services.

10. FOLLOW-UP AND AFTER CARE

a. Follow-up or after care is accomplished by planning and coordinating the care, treatment, and rehabilitation deemed necessary by the IDT after the Veteran is discharged from the inpatient program.

b. Follow-up care is planned by the IDT while the Veteran is an inpatient, and it is documented in the discharge summary.

c. Prior to discharge, the social worker designated for the rehabilitation team works with the Veteran and Veteran's family to resolve issues regarding housing, residential care, financial support, home care, and any other issues to ensure continued recovery or maintenance after discharge.

d. IDT members must provide follow-up care and treatment by the designated rehabilitation, as indicated within the discharge summary.

11. BUSINESS PROCEDURES

VHA Business Office procedures including compliance for therapy and rehabilitation services billing and coding guidelines, documentation of treatment plans/plans of care, certification and recertification of plans of care, revenue codes and modifiers, and reimbursement for therapy services are updated annually by the PM&RS National Program Office and the VHA Office of Community Care, Revenue Operations and VHA Health Information Management Coding Council.

a. VHA Community Care Knowledge Base Navigation Portal is available in Chapter 6 Section A: Kinesiotherapy Coverage and Billing Requirements:
https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050097/Section-A-Kinesiotherapy-Coverage-and-Billing-Requirements. **NOTE:** This is an internal VA Web site that is not available to the public.

b. PM&RS Therapy and Rehabilitation Services (PTs, OTs, PTAs, OTAs, KTs): General Information on Coverage for Therapy Services; Billing Guidelines; Eligible Therapy and Rehabilitation Services; Maintenance Therapy; Treatment Plans/Plans of Care for Therapy Services; Changes to a Treatment Plan/Plan of Care; Certification and Recertification of Plan of Care; Therapy and Rehabilitation Documentation Requirements; Billing and Coding Rules for Therapy and Rehabilitation Services; and Revenue Codes and Modifiers for Therapy Services is available in Chapter 7, Section C:
https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. **NOTE:** This is an internal VA Web site that is not available to the public.

c. Claims and Reimbursement for Therapy Services is available in Chapter 7:
https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. **NOTE:** This is an internal VA Web site that is not available to the public.

REHABILITATION CONTINUUM OF CARE CHART RECOMMENDATIONS

The below chart indicates the rehabilitation continuum of care recommendations. Acronyms used in this table include Medical Doctor (M.D.), Certified Rehabilitation Registered Nurse (CRRN), Length of Stay (LOS), Functional Independence Measure (FIM™), Resource Utilization Group (RUG)/ Functional Related Group (FRG), Hours Per Patient Day (HPPD), Physical Medicine and Rehabilitation Services (PM&RS), Commission on Accreditation for Rehabilitation Facilities (CARF), The Joint Commission (TJC), Resident Assessment Instrument (RAI), Geriatrics and Extended Care (GEC), Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI), and Minimum Data Set (MDS). **NOTE:** *Inpatient High Intensity is recommended for Comprehensive Integrated Inpatient Rehabilitation (CIIPR) Units.*

	Inpatient High Intensity	Inpatient Mod Intensity	Inpatient Low Intensity	Inpatient Supportive	Outpatient
Responsible Provider	PM&RS	PM&RS GEC	PM&RS GEC	GEC/ Restorative Nursing	Ordering Provider
MD or Licensed Practitioner Visits	Daily	Weekly	Every 30 days	Every 30 days	As clinically indicated
Rehabilitation Team	Yes	Yes	Consultative	Consultative	As Indicated
Presence of CRRN or Nurse with Rehabilitation Experience	Yes, direct	Yes, direct or consultative	Yes, consultative	As clinically indicated	As clinically indicated
Expected LOS (FIM™/RUG/FRG)	Short Stay: Determined by FRG Classification Typically less than 30 days	Short Stay: Determined by FRG Classification Typically less than 30 days	Short Stay: Determined by FRG Classification Typically less than 90 days	Benchmark Diagnosis; May be >90 days; Rehab Involvement: Limited	Length of treatment determined by benchmark for diagnosis

	Inpatient High Intensity	Inpatient Mod Intensity	Inpatient Low Intensity	Inpatient Supportive	Outpatient
Restorative Care	Not Applicable	Not Applicable	Restorative Nursing plus rehabilitation therapies, greater than 2 Nursing Activities	Restorative Nursing. 6 days/week, 15min/day, greater than 2 Nursing Activities	Not Applicable
Therapy Disciplines	Minimum of 2	Minimum of 2	Minimum of 1	As clinically indicated	As clinically indicated
Therapy HPPD	Minimum of 3	Minimum of 2	Minimum of 1	As clinically indicated	As clinically indicated
Therapy Days per Week	Minimum of 5	Minimum of 5	Minimum of 3	As clinically indicated	As clinically indicated
Accreditation Recommendations	CARF and TJC	CARF and/or TJC	CARF and/or TJC	LTC TJC	Outpatient CARF Outpatient Homecare or TJC
Beds in Designated Area	Yes	Yes	Not Required	No	NA
Discharge Destination	Community	Community	Community	Variable	NA
Outcome Measures	FIM™ or section GG (IRF PAI or RAI MDS)	FIM™ or section GG (IRF PAI or RAI MDS)	FIM™ or section GG (IRF PAI or RAI MDS)	Determined by Program	Determined by Program
Continuous Improvement Measures	Per CARF Standards and RAI MDS if in CLC	CARF and/or RAI/MDS Quality Measures if in CLC	RAI MDS CARF and/or Quality Measures	RAI MDS Quality Measures	Per Departmental Procedures

**PROCEDURES FOR DOCUMENTATION OF KINESIOTHERAPY SERVICES IN
COMMUNITY LIVING CENTERS RESIDENT ASSESSMENT INSTRUMENT MINIMUM
DATA SET**

1. MINIMUM DATA SET

a. The Minimum Data Set (MDS) is a standardized, comprehensive clinical assessment tool for all Veterans in Department of Veterans Affairs (VA) Community Living Centers (CLCs). VA does not use the MDS for the purpose of Centers for Medicare and Medicaid (CMS) billing. Rather, the MDS facilitates care management in CLCs by identifying potential health problems, strengths, and preferences of Veterans and quality comparisons with services available within private nursing homes in the community. Disciplines currently authorized to record in section O of MDS include:

(1) Speech-Language Pathology and Audiology Services.

(2) Occupational Therapy (OT).

(3) Physical Therapy (PT).

(4) Respiratory Therapy.

(5) Psychological Therapy. **NOTE:** *Psychological therapy services are ordered within the context of a rehabilitation regimen and performed by a licensed mental health professional.*

(6) Recreational Therapy.

b. Kinesiotherapy (KT) services within VA CLCs are provided within one of three treatment programs listed below and will document minutes within Section S, which is organizational specific to VA:

(1) Short-term, goal-oriented, skilled rehabilitative care programs;

(2) Formal restorative nursing programs, as defined by CMS and published in MDS User's Guide; and

(3) Other long-term maintenance services provided outside goal-directed rehabilitation programs or formal restorative nursing programs.

**2. MINIMUM DATA SET GENERATED REHABILITATION RESOURCE UTILIZATION
GROUPS (IV)**

d. The Minimum Data Set (MDS) Generated Rehabilitation Resource Utilization Groups (IV) is available on the PM&RS SharePoint:

<https://vaww.infoshare.va.gov/sites/rehab/pmrs/PMRS%20Policies/Forms/AllItems.aspx>

[?RootFolder=%2Fsites%2Frehab%2Fpmrs%2FPMRS%20Policies%2FPMRS%20Directives&FolderCTID=0x012000BAE8604B49079A4BAE1C57EA20C65271&View=%7B08BC1029%2D1375%2D4476%2DBFB7%2DDCD8E4935DB6%7D](https://www.va.gov/sites/rehab/fpmrs/FPMRS%20Policies/FPMRS%20Directives/CTID=0x012000BAE8604B49079A4BAE1C57EA20C65271&View=%7B08BC1029%2D1375%2D4476%2DBFB7%2DDCD8E4935DB6%7D). **NOTE:** This is an internal VA Web site that is not available to the public. **NOTE:** RUG IV is the current version of the patient classification system for long term care patients used by CMS to determine reimbursement levels for skilled nursing home facilities. It categorizes Veterans into a payment group based on care and resource needs that are documented in the MDS.

CALCULATION PROCEDURES FOR DETERMINING CARF ACCREDITATION IN COMMUNITY LIVING CENTERS

1. CALCULATE PROCEDURES

a. Veterans in the High, Very High, and Ultra High Rehabilitation Resource Utilization Groups (RUG) categories receive interdisciplinary rehabilitation care in sufficient intensity to align with services provided on a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited inpatient rehabilitation neighborhood. The following is recommended based on questions from the field.

b. Rehabilitation RUG categories are used to support rehabilitation bed need, following the steps below to determine the estimated number of rehabilitation beds needed in Community Living Center (CLC) neighborhoods:

(1) Sum the total uniques for High, Very High, and Ultra High rehabilitation services for a 12 month period.

(2) Ultra High: RUX, RUL, RUC, RUB, RUA

(3) Very High: RVX, RVL, RVC, RVB, RVA

(4) High: RHX, RHL, RHS, RHB, RHA

(5) Multiply the total count of uniques by the average length of stay on CLC short stay rehabilitation neighborhoods (currently 31 days) to obtain total bed days of care (BDOC).

(6) Divide the total BDOC by 365 (number of days in a year) to get a raw average daily census calculation.

(7) Facilities with a calculation of five or more average daily census must pursue CARF accreditation for the inpatient rehabilitation.

NOTE: *Some cases in the Medium Rehabilitation RUG category may also be receiving services comparable to a CARF accredited rehabilitation neighborhood. Facilities may utilize cases in the medium rehabilitation RUG category in their calculations depending on the composition of the rehabilitation team and intensity of services provided.*

2. CARF ACCREDITATION

CARF accreditation is not required for all short stay rehabilitation CLC bed units (classified using Treating Specialty Code 64). CLC units may provide interdisciplinary rehabilitation care at the required complexity (multiple disciplines) and intensity (hours and days of care provided), but not have sufficient volume to support CARF

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accreditation. These sites must continue to provide interdisciplinary rehabilitation care on CLC neighborhood, and Geriatrics and Extended Care (GEC) and Physical Medicine and Rehabilitation Services (PM&RS) facility chief or designee and director must analyze demand on an annual basis to determine the need to pursue CARF accreditation.

SCOPE OF PRACTICE STANDARDS FOR REHABILITATION THERAPY

1. Scope of Practice. The scope of practice is established by the professional organization for each rehabilitation discipline describes the services and procedures that the rehabilitation provider is permitted to perform within their professional license, registration or certification.

a. The scope of practice for kinesiotherapy established by the Council on Professional Standards for Kinesiotherapy, Inc. can be accessed on the on the American Kinesiotherapy Association's (AKTA) Web site at: <https://akta.org/wp-content/uploads/2018/01/Scope-Of-Practice-revised-Jan-2018-Final.pdf>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

b. The scope of practice for physical therapy can be accessed on the American Physical Therapy Association's (APTA) Web site at: <http://www.apta.org/ScopeOfPractice/>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

c. The summary of interrelated constructs within occupational therapy is described in the American Journal of Occupational Therapy, Occupational Therapy Practice Framework: Domain and Process which can be accessed at: <https://ajot.aota.org/article.aspx?articleid=1869228>. **NOTE:** *This Web site is outside VA control and may or may not conform to Section 508 of the Rehabilitation Act of 1973.*

d. Rehabilitation_professionals working in Physical Medicine and Rehabilitation Services (PM&RS) have specialized skills and knowledge, based on their education, clinical training, and experience. These are necessary to address the complex rehabilitative needs of Veterans. Specialized skills and knowledge must be reflected within the following:

- (1) Functional statement or position description;
- (2) Certifications;
- (3) Continuing education records;
- (4) Competencies;
- (5) Orientation training; and
- (6) Scope or standards of practice.

2. PM&RS Rehabilitation Therapists. The following categories are described in detail below.

a. **Kinesiotherapist.** Kinesiotherapists (KTs) provide evidence-based exercise techniques adapted to enhance the strength, endurance, and mobility of individuals with functional limitations or those requiring extended physical conditioning. KTs administer musculoskeletal, neurological, ergonomic, biomechanical, psychosocial, and task-specific functional evaluations to provide an individualized, goal-oriented treatment plan with skilled interventions. Such interventions may include: therapeutic exercises, complex wheelchair mobility training, seating and positioning, gait and balance training, training with assistive devices, orthotic and prosthetic devices, assistive technology and adaptive equipment, neuromuscular re-education and strategies to educate the Veteran and caregiver on techniques to improve safety, function, movement and wellbeing. KT's emphasize the psychological as well as physical interventions to enhance behavior change for a holistic approach to rehabilitation. KT's also may have specialty certifications with an advanced level of expertise such as, but not limited to: driver instructor training, aquatic therapy, health coaching, ergonomics, and cardiac rehabilitation.

b. **Occupational Therapist.** Occupational therapists (OTs) provides specific evaluation and treatment analysis of occupational performance in the areas of: ADLs; IADLs education; work; play; leisure; and social participation. These evaluations include evaluations of performance patterns, (habits, routines, and roles), body structure, body functions (e.g. neuromuscular, sensory, visual, perceptual, and cognitive), performance skills (motor, process, communication, and interaction skills), and context and activity demands. Common treatment interventions, which include, but are not limited to: training in self-care, home management, and community or work reintegration to enhance safety and performance, specialized training in the use of assistive technology, adaptive devices, and orthotic and prosthetic devices.

c. **Physical Therapist.** Physical therapists (PTs) evaluate muscle strength, balance and coordination, joint flexibility, physical endurance, locomotion and transfer mobility, and pain. Specific assessment techniques include, but are not limited to: manual muscle tests; gait analysis; posture assessment, range of motion; and neurological examination. Common interventions that include, but are not limited to: therapeutic exercises, manual intervention, neuromuscular re-education, vestibular rehabilitation, resistive muscle strengthening, gait training, and use of prostheses and orthoses; recommendations for specialized equipment; use of modalities such as transcutaneous electrical nerve stimulator (TENS), functional muscle stimulation, ultrasound, and Veteran and family education.

d. **Rehabilitation Therapist.** A rehabilitation therapist is a specialty trained, licensed, registered or certified professional, who evaluates and provides treatment to Veterans to help them meet their functional rehabilitation goals. Rehabilitation therapists are physical therapists, occupational therapists, kinesiotherapists, speech-language pathologists, and recreation therapists.

e. **Physiatrist.** A physiatrist is a physician who is board certified, or trained and board eligible, in Physical Medicine and Rehabilitation. Physiatrists specialize in impairments and disease processes that necessitate admission to rehabilitation

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programs. Psychiatrists direct a comprehensive rehabilitation team of professionals, which include: physical therapists, occupational therapists, kinesiotherapists, recreational therapists, rehabilitation nurses, psychologists, social workers, speech-language pathologists, and others working together to manage disorders that alter a Veteran's functional independence.

OUTCOMES FOR INPATIENT REHABILITATION UNITS

1. **Inpatient Rehabilitation Units.** Inpatient units focused on providing interdisciplinary rehabilitation care are identified using the following treating specialty codes:

a. **Rehabilitation Medicine.** Treating Specialty Code 20 is used to identify an admission for rehabilitation services in a PM&R bed section associated with acute hospital beds.

b. **Community Living Center (CLC).** Treating Specialty Code 64 is used to identify an admission to a VA CLC bed when, on admission, the Veteran's expected length of stay is 90 days or less. The admission for short stay rehabilitation is time-limited, goal-directed, skilled care for the purpose of returning the Veteran to functioning as independently as possible.

c. **Polytrauma Rehabilitation Center (PRC).** Treating specialty code 112 (1N) is used to designate specialty inpatient rehabilitation treatment provided at the PRCs. Polytrauma beds are classified separately from the general rehabilitation beds operating at the medical centers with PRCs. Use of the Polytrauma Rehabilitation treating specialty code is limited to the dedicated PRC beds is used for PRC inpatient units providing the full continuum of inpatient rehabilitation services to seriously ill and injured Veterans and Service Members.

2. **Rehabilitation Outcomes.** VA medical facilities integrate collection of outcomes for inpatient rehabilitation beds into their clinical documentation practice to ensure the provision of quality rehabilitation care. Rehabilitation outcomes can be collected through two primary instruments.

a. Functional Independence Measure (FIM™) captured through the Functional Status and Outcomes Database (FSOD) for Rehabilitation located at the Austin Information and Technology Center (AITC).

b. Section GG (Functional Abilities and Goals) is embedded in the Centers for Medicare and Medicaid Services (CMS) Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument (PAI) and in the CMS Resident Assessment Instrument (RAI) Minimum Data Set (MDS).

3. Facility Physical Medicine and Rehabilitation (PM&R) Service Chief will designate at least one person to coordinate the administration of the rehabilitation outcome tools, data entry, and management of the facility's data. This designee is the primary liaison to the PM&RS Program Office for monitoring and tracking outcomes.

NOTE: It is recommended the designee be a rehabilitation manager, therapist, TBI case manager, or quality management person actively involved in rehabilitation care management.

a. Staff utilizing FIM™ and FSOD are credentialed in the administration of the FIM assessment tool required by the UDSmr Offices (<https://www.udsmr.org>) in Buffalo, NY, and the PM&RS Program Office at VA Central Office (VHA12RPS6PMRS@va.gov).

b. Staff utilizing section GG can reference the CMS IRF Quality Reporting Program (QRP) for training resources: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training>