

VHA OUTPATIENT AMPUTATION SPECIALTY CLINICS

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive states policy and requirements for VHA's Outpatient Amputation Specialty Clinics which provide care and rehabilitation services to Veterans with limb amputations.
- 2. SUMMARY OF MAJOR CHANGES:** Major changes include updating performance standards of Outpatient Amputation Specialty Clinics.
- 3. RELATED ISSUES:** VHA Directive 1045, Coding, Market Analyses and Contract Guidance for Prosthetic Limb and/or Custom Orthotic Device Procurement, dated May 12, 2020; VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017; VHA Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018; VHA Directive 1936, Accreditation of VA Orthotic, Prosthetic and Pedorthic Facilities and Personnel Credentialing, dated September 16, 2019; VHA Directive 1170.03, Physical Medicine and Rehabilitation Services, dated November 5, 2019.
- 4. RESPONSIBLE OFFICE:** The Chief Officer for Rehabilitation and Prosthetic Services (12RPS) is responsible for the contents of this directive. Questions may be referred to the Executive Director, Physical Medicine and Rehabilitation Service, at VHA12RPSRehabandProstheticsAction@va.gov or 202-461-7444.
- 5. RESCISSIONS:** VHA Handbook 1173.3, Amputee Clinic Teams And Artificial Limbs, dated June 4, 2004, is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of March 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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

/s/ Beth Taylor, DHA
Assistant Under Secretary for Health
for Patient Care Services

NOTE: All references herein to Department of Veterans Affairs (VA) and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

March 8, 2021

VHA DIRECTIVE 1173.3

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VHA OUTPATIENT AMPUTATION SPECIALTY CLINICS

1. PURPOSE

This Veterans Health Administration (VHA) directive maintains policy for operating VHA Outpatient Amputation Specialty Clinics, designed to assist VHA, Veteran Integrated Services Network (VISN) and Department of Veterans Affairs (VA) medical facility leadership in establishing, maintaining and improving programs and services for Veterans with limb amputation. **AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 1706(b); 7301(b); Title 38 Code of Federal Regulation (C.F.R.) § 17.150.

2. BACKGROUND

a. Throughout its history, VHA has placed a high priority on care that is provided to Veterans with limb amputation. Amputations have medical, physical, social and psychological ramifications for the Veteran and the Veteran's family. Management of Veterans with amputation requires a comprehensive, coordinated and interdisciplinary program of outpatient services. This includes offering the latest practices in medical interventions, prosthetic limbs, assistive technology and rehabilitation strategies to restore function and thereby optimize quality of life.

b. The VHA Amputation System of Care (ASoC) is an integrated national health care delivery system that provides patient-centered, gender-sensitive, lifelong, holistic care and care coordination for Veterans with limb loss. The outpatient clinic setting is an essential environment for the provision of amputation care and rehabilitation services. Through the provision of these services, either in-person or using telehealth, VHA strives to minimize disability and to enable the highest level of functional, social, vocational and recreational success for Veterans with amputation. **NOTE:** *For more information regarding ASoC, see VHA Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018.*

c. The Prevention of Amputations in Veterans Everywhere (PAVE) program and the Outpatient Amputation Specialty Clinics are closely linked and coordinate efforts in order to address the prevention of first amputation, the rehabilitation of Veterans who have had an amputation and the prevention of secondary amputation progression. Outpatient Amputation Specialty Clinics can provide care for Veterans with complex limb trauma, other injuries or disease processes resulting in a high likelihood of requiring a limb amputation in the future. **NOTE:** *For more information on the PAVE program, see VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017.*

d. This directive describes the interdisciplinary team approach utilized in the Outpatient Amputation Specialty Clinic to provide specialized expertise in amputation rehabilitation incorporating the latest practices in medical management, rehabilitation therapies, prosthetic limbs and assistive technologies. The requirements described in this directive reflect efforts to systematize the provision of outpatient rehabilitative care for Veterans with amputation across VHA. It is anticipated that these procedures will

require updates over time in conjunction with advances in technology and clinical practice guidelines. **NOTE:** For more information about clinical practice guidelines, see <https://www.healthquality.va.gov/>.

3. POLICY

It is VHA policy that all VA medical facilities implement and maintain Outpatient Amputation Specialty Clinic services in accordance with their designation within the ASoC to provide life-long care to Veterans with limb amputation in order to restore Veterans to their maximum level of function and greatest quality of life.

4. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for:

(1) Supporting the program office with implementation and oversight of this directive.

(2) Reviewing and approving proposed changes to ASoC and Outpatient Amputation Specialty Clinic services submitted by the Chief Officer for Rehabilitation and Prosthetic Services.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges.

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

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

(1) Providing oversight for compliance for all VISNs and VA medical facilities with this directive and ensuring corrective action is taken if non-compliance was identified.

(2) Reviewing proposed modifications to ASoC and Outpatient Amputation Specialty Clinic services with the National Director of Physical Medicine and Rehabilitation (PM&R) Program.

(3) Communicating proposed changes to Outpatient Amputation Specialty Clinic services to the Assistant Under Secretary for Health for Patient Care Services as well as to each VISN.

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

(1) Providing national program leadership for the rehabilitation, health care and services for Veterans with amputation.

(2) Reviewing proposed modifications to ASoC and Outpatient Amputation Specialty Clinics with the Chief Officer for Rehabilitation and Prosthetic Services.

(3) Reviewing ASoC annual strategic plans, reports, guidelines and VHA policies submitted by the National Program Manager, ASoC.

f. **National Director, Amputation System of Care.** The National Director, ASoC is responsible for:

(1) Ensuring development and implementation of initiatives that enhance the ability of Outpatient Amputation Specialty Clinics to serve the needs of eligible Veterans.

(2) Ensuring development and execution of the ASoC annual strategic plan.

(3) Overseeing the ASoC annual budget with the National Director, PM&R Program.

(4) Providing subject matter expertise to VHA providers involved in amputation specialty care.

(5) Proposing modifications to ASoC and Outpatient Amputation Specialty Clinic services for review by the Chief Officer for Rehabilitation and Prosthetic Services.

(6) Evaluating potential opportunities with National Program Manager, ASoC to collaborate with external and internal stakeholders, such as Veterans Service Organizations, Department of Defense, the Extremity Trauma and Amputation Center of Excellence, VHA Orthotics and Prosthetics Program, PAVE and private organizations (e.g., Amputee Coalition), to strengthen program development and partnerships on strategic initiatives.

(7) Overseeing the development and implementation of education related to amputation rehabilitation, including clinical practice guidelines.

g. **National Program Manager, Amputation System of Care.** The National Program Manager, ASoC, is responsible for:

(1) Providing budget and fiscal management of the ASoC to assist the National Director, PM&R Program and National Director, ASoC.

(2) Providing training and consultation to the Regional Amputation Centers (RACs) and Polytrauma Amputation Network Sites (PANS) on preparation for review by external accrediting organizations. **NOTE:** For more information regarding RACs, PANS see VHA Directive 1172.03(1).

(3) Ensuring the development of a national ASoC communication plan with all components of the ASoC including through conference calls, live meetings, teleconferences and face-to-face meetings.

(4) Preparing ASoC annual strategic plans, reports, guidelines and VHA policies and submitting these documents to the National Director, PM&R Program.

(5) Evaluating potential opportunities with National Director, ASoC to collaborate with external and internal stakeholders to strengthen program development and partnerships on strategic initiatives.

h. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Implementing and supporting Outpatient Amputation Specialty Clinics, balancing local conditions for Veteran access to the clinic with adherence to national guidelines and directives while respecting the Veteran's care location preference.

(3) Supporting all administrative components of the Outpatient Amputation Specialty Clinics described in this directive.

(4) Providing and facilitating necessary communication, resources and quality improvement efforts across all VISN VA medical facilities in order to maintain expertise and quality services.

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

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(2) Implementing the appropriate staffing, clinical expertise and VA medical facility infrastructure to establish new or maintain existing operations of an Outpatient Amputation Specialty Clinic.

(3) Ensuring oversight and accountability of the Outpatient Amputation Specialty Clinic within the VA medical facility.

(4) Collaborating with the operational leadership of ASoC, including the ASoC National Director and National Program Manager, to maintain services of the Outpatient Amputation Specialty Clinic.

(5) Ensuring public affairs efforts are designed to inform various stakeholders regarding the services provided through the Outpatient Amputation Specialty Clinic.

(6) Designating at least one person to serve as an Amputation point of contact (APoC) for VA medical facilities that do not have an Outpatient Amputation Specialty Clinic. This APoC is knowledgeable about the Outpatient Amputation Specialty Clinic and the available types of services it can offer. **NOTE:** For more information regarding APoC, see VHA Directive 1172.03(1).

j. **VA Medical Facility Outpatient Amputation Specialty Clinic Team.** The VA medical facility Outpatient Amputation Specialty Clinic team is an interdisciplinary team, consisting of core and elective members, that is responsible for:

(1) Providing assessment and treatment for amputation-related needs. **NOTE:** For more information about prosthesis candidacy determination and prescription, see Appendix B.

(2) Providing education on amputation care to VA medical facility staff, Veterans and caregivers.

(3) Ensuring a safe environment for the Veteran during the clinic visit. **NOTE:** For more information about the Outpatient Amputation Specialty Clinic Team, see Appendix A.

(a) **Prescribing Clinician.** The preferred team member is a board-certified PM&R physician who possesses clinical expertise in amputation care. In the absence of a PM&R physician, some clinics may enlist physicians from other services who have clinical expertise in amputation care. In the event that a physician is not available either in-person or through telehealth, the physician role can be filled by other types of independent practitioners such as a Certified Nurse Practitioner or Physician Assistant if the independent practitioner possesses the required clinical expertise in amputation care. This physician is a core member of the team and is responsible for:

1. Oversight of all amputation-related care needs for Veterans seen in the Outpatient Amputation Specialty Clinic.

2. Completing the prosthetic prescription and all required documentation and coding associated with the Outpatient Amputation Specialty Clinic visit.

3. Assuring medical appropriateness and readiness for prosthetic restoration.

4. Addressing amputation-specific medical conditions.

5. Referring the Veteran for additional services as indicated.

(b) **Therapist.** The therapist can be a physical therapist, occupational therapist or kinesiotherapist with experience in limb loss rehabilitation. The therapist is a core member of the team and is responsible for:

1. Performing functional assessments, objective tests and measures.
2. Providing recommendations for prosthesis use and appropriate rehabilitation needs including instruction and education in therapeutic exercise to optimize patient function.
3. Assessing and issuing equipment, prosthetic devices and home exercise programs as appropriate.
4. Providing and coordinating functional skills training with the prosthesis (e.g., gait training with a lower limb prosthesis or ADL training with an upper limb prosthesis).

(c) **Prosthetist.** The prosthetist is a core member of the team and is responsible for:

1. Providing clinical expertise in prosthetic components and function, including soft goods; and developing and coding the prosthetic prescription.
2. Performing adjustments and alignment changes to prostheses.
3. As necessary, communicating with community clinicians to coordinate follow-up care needs.

(d) **Amputation Rehabilitation Coordinator.** For RACs and PANS, the ARC is a core member of the team and serves as a subject matter expert for Outpatient Amputation Specialty Clinic services. The ARC is responsible for:

1. Providing care coordination across ASoC and across the continuum of care for the Veteran.
2. Serving as the point of contact for information about ASoC and amputation care for their VA medical facility and VISN. **NOTE:** For more information about ARC responsibilities, see VHA Directive 1172.03(1).

(e) **Prosthetic Representative.** The Prosthetic and Sensory Aids Services (PSAS) Prosthetic Representative is an elective member of the team and is responsible for:

1. Overseeing the procurement of prosthetic devices, supplies and other soft goods in accordance with current PSAS regulations and directives. This includes serving as a liaison to the PSAS Chief and representatives from contracting and community prosthetic providers (CPPs).
2. Informing Veterans about other programs that may help meet their medical needs and for which they may be eligible, such as the Home Improvement and Structural Alterations or Automobile Adaptive Equipment programs.

5. TRAINING

There are no formal training requirements associated with this directive.

6. 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 VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

7. REFERENCES

- a. 38 U.S.C. §§ 543, 1706(b), 1710, 7301(b).
- b. 38 C.F.R. § 17.150.
- c. VHA Directive 1045, Healthcare Common Procedure Coding System (HCPCS) List for Prosthetic Limb and/or Custom Orthotic Device Prescription, dated December 30, 2013.
- d. VHA Directive 1170.03, Physical Medicine and Rehabilitation Services, dated November 5, 2019.
- e. VHA Directive 1172.03(1), Amputation System of Care, dated August 3, 2018.
- f. VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017.
- g. VHA Directive 1936, Accreditation of VA Orthotic, Prosthetic, and Pedorthic Facilities and Personnel Credentialing, dated September 16, 2019.

OUTPATIENT AMPUTATION SPECIALTY CLINIC TEAM

1. TEAM DESCRIPTION

a. The Outpatient Amputation Specialty Clinic Team is an interdisciplinary team consisting of, at a minimum, but not limited to, a physician (or prescribing clinician), a therapist and a prosthetist, providing assessment and treatment for amputation-related needs. The Veterans Health Administration (VHA) has organized these teams into the Amputation System of Care (ASoC) to leverage the expertise throughout the system to best meet the needs of the Veteran with limb loss. **NOTE:** *For more information about prescribing clinicians, see paragraph 4.j.(3)(a).*

b. Depending on the available resources at the Department of Veterans Affairs (VA) medical facility and identified needs of the Veteran, other providers and support personnel may be incorporated into the interdisciplinary team. Other potential clinical team member disciplines include, but are not limited to Social Work, Nursing, Wound Care, Surgery, Podiatry, Vocational Counseling and Mental Health. Additional non-clinical team members include Prosthetic Representatives. In the event that a physician is not available either in-person or using telehealth, the physician role can be filled by other types of independent practitioners such as a Certified Nurse Practitioner or Physician Assistant if the independent practitioner possesses the required clinical expertise in amputation care.

2. ASSESSMENT AND MANAGEMENT BY TEAM

Outpatient Amputation Specialty Clinic Teams provide assessment and treatment for amputation-related care needs for Veterans with limb loss by:

a. Effectively utilizing all available modalities for care provision including, but not limited to; in-person visits, telehealth visits, telephone visits and secure messaging.

b. Assessing Veterans, with or at risk for limb loss, for amputation-related care and rehabilitation needs.

c. Prescribing appropriate prosthetic devices or components consistent with the Veteran's abilities and needs. This requires identifying changes in abilities and care needs over time and modifying the prosthetic prescription as necessary.

d. Inspecting and evaluating the fit and function of all prosthetic devices prescribed and issued to a Veteran.

e. Conducting recommended annual follow-up examinations and treatments of Veterans with amputation at regular intervals to ensure continuity and lifelong management based on clinical care needs.

f. Referring Veterans to the appropriate service(s) to address any amputation-related care needs. This may include, but is not limited to pain management, seating and mobility, physical therapy, occupational therapy, kinesiotherapy, nutrition and food services, whole health coaching, mental health services, adaptive sports and recreation, driver rehabilitation, vocational rehabilitation, wound care services, podiatry and vascular or orthopedic surgery. **NOTE:** *Referral to the community for these services will be based on MISSION Act eligibilities.*

g. Establishing, updating and documenting a plan of care with an appropriate follow up plan at each Outpatient Amputation Specialty Clinic appointment.

(1) Veterans with no new amputation-related care issues or equipment needs should be contacted annually at a minimum. Contact can occur via telephone, telehealth visits, in-person visits or secure messaging as clinically appropriate.

(2) When a new complete prosthetic limb or new prosthetic limb components are prescribed or ordered, checkout of the new device or component(s) is completed to assess the fit and function of the prescribed device(s). Checkout completion can occur via telephone, telehealth visits or in-person visits as clinically appropriate. **NOTE:** *For more information about prosthetic checkout, see Appendix B, paragraph 2.g.*

(3) The Veteran is provided with the Outpatient Amputation Specialty Clinic Team contact information and educated on resources available to communicate with the Outpatient Amputation Specialty Clinic Team. This may include, but is not limited to, use of a secured patient portal and telephone contact information.

3. ELIGIBILITY AND ACCESS TO OUTPATIENT AMPUTATION SPECIALTY CLINICS

a. Outpatient Amputation Specialty Clinics serve Veterans with limb loss from any etiology. These Clinics also provide care for individuals with complex limb trauma and those with other injuries or disease processes resulting in a high likelihood of requiring a limb amputation in the future.

b. The VA medical facility where Outpatient Amputation Specialty Clinic and rehabilitative services are to be provided will be determined collaboratively by the clinical team, the Veteran and the Veteran's family, based on individual needs, goals and preferences.

c. VA providers can refer eligible Veterans to the Outpatient Amputation Specialty Clinic for evaluation and management as clinically indicated. Eligible Veterans can access Outpatient Amputation Specialty Clinic services directly through Patient Self-Referral Direct Scheduling (PSDS) procedures. Online Scheduling services can also be utilized by eligible Veterans to request or schedule an appointment in the Outpatient Amputation Specialty Clinic.

4. REFERRAL AND SCHEDULING

a. Veterans with limb amputation or complex limb trauma and those with other injuries or disease processes resulting in significant likelihood of requiring a limb amputation in the future are to be scheduled in an Outpatient Amputation Specialty Clinic for assessment, consultation and education related to amputation care. Referral to another VA medical facility for amputation care is indicated when:

(1) The VA medical facility that the Veteran receives care from does not have an Outpatient Amputation Specialty Clinic Team and therefore would benefit from a referral to another VA medical facility for assessment by a specialty team. **NOTE:** For more information about the organizational structure of ASoC referrals, see Directive 1172.03(1), VHA Amputation System of Care, dated August 3, 2018.

(2) The Veteran appears to be an appropriate candidate for evaluation for a highly specialized or experimental type prosthetic device which requires the involvement of a specialized Outpatient Amputation Specialty Clinic Team.

b. Hospitalized or domiciled Veterans can be referred to the Outpatient Amputation Specialty Clinic Team for assessment within their designated VA medical facility. If the VA medical facility where the Veteran is located does not have an Outpatient Amputation Specialty Clinic, the Veteran can be referred to another VA medical facility. Whenever possible, TeleAmputation Care services must be utilized.

c. Whenever possible, the treatment interventions and care recommendations must be carried out at the Veteran's designated VA medical facility with consultation and input from the prescribing Outpatient Amputation Specialty Clinic Team.

d. Clinic Stop Code 211 must be used for the Outpatient Amputation Specialty Clinic. As per the Managerial Cost Accounting System Outpatient Identifiers, the 211 Stop Code is used to record a Veteran's visit for evaluation or treatment prior to or following removal of a limb or other appendage. The Veteran is evaluated by a team led by a physiatrist that includes provider and support services.

5. ROLE OF THE COMMUNITY PROSTHETIC PROVIDER

a. Many VA medical facilities establish contracts with CPPs to fabricate and fit VA prescribed and coded prostheses for Veterans with amputations. The CPP is considered a valued member of the team and is expected to provide both technical prosthetic knowledge as well as supplemental details as they pertain to the Veteran's limb loss or prosthesis use. When appropriate, the CPP is encouraged to attend the scheduled VA Outpatient Amputation Specialty Clinic appointment when requested by the Veteran or the VA amputation specialty care team.

b. Appropriate CPP involvement in the Outpatient Amputation Specialty Clinic includes the following considerations:

(1) The CPP is invited to participate in the clinic visit at the discretion of the Veteran and the VA amputation specialty care team. Both the VA amputation specialty care team and the Veteran must be in agreement for the CPP to attend the visit.

(2) The CPP respects Veteran privacy and safeguards all personal health information.

(3) The CPP serves as clinical partner and provides clinical input as well as technical expertise regarding prosthesis fitting and function.

(4) The CPP provides accurate and efficient provision of care and services.

(5) As evident during prosthetic checkout, the prosthetic device provided by the CPP to the Veteran must match the prescription written by the prescribing physician and codes assigned by the VA prosthetist.

(6) The CPP provides the team with relevant care information as it pertains to the current treatment plan for the Veteran.

(7) The CPP may not solicit Veterans for referral or business while attending clinic or on the grounds of the VA medical facility.

(8) The CPP may provide recommendations for prosthetic prescription and component trials to the Outpatient Amputation Specialty Clinic Team. If the Outpatient Amputation Specialty Clinic Team agrees to the recommendations, a prescription including the recommendations must be provided prior to commencement of any trial fitting or fabrication by the CPP.

PROSTHESIS CANDIDACY DETERMINATION AND PRESCRIPTION

1. CANDIDACY DETERMINATION

a. The Veteran's personal preferences, mobility needs and functional goals are to be solicited and considered as central components in development of the individualized prosthesis prescription and treatment plan.

b. Evaluations must be performed by qualified professionals with requisite clinical expertise. The evaluation of each new Veteran with amputation should include all of the following:

- (1) Reason for attending amputee clinic.
- (2) Veteran's current medical status.
- (3) Medications.
- (4) Date of amputation and medical facility where amputation was performed.
- (5) Reason for amputation.
- (6) Current height and weight.
- (7) Premorbid and current functional status and level of activity.
- (8) Any problems with the prosthesis if currently using a prosthesis.
- (9) History of prosthesis use.
- (10) History of residual limb complications.
- (11) Pertinent medical findings including musculoskeletal conditions.
- (12) Full physical examination of Veteran's residual and contralateral limb for skin integrity, strength, ROM and sensation.
- (13) Gait or other function with the current prosthesis.
- (14) Home environment and relevant psychosocial considerations.

c. The following factors should be taken into consideration with prescription of a prosthesis:

- (1) Potential functional benefit can be clearly identified and reasonably anticipated in one or more of the following categories:

- (a) Mobility including transfers, household and community ambulation.
- (b) Performance of Activities of Daily Living (ADL).
- (c) Psychosocial (e.g. clear benefit from cosmesis, supports adjustment to disability).

(2) Potential benefit of prosthesis use compared to anticipated risk. For example, the benefit of improved mobility when using a lower limb prosthesis should be weighed against potential increased fall risk.

2. PRESCRIPTION CONSIDERATIONS

a. Each prosthetic limb candidate should be assessed by the clinic team to determine the Veteran's needs and goals. If a new or replacement prosthesis is indicated, advantages and disadvantages of available technology are discussed with the Veteran who is involved in the decision-making process.

b. The prescription for a lower limb prosthesis should include the following:

- (1) Diagnosis (includes level of amputation and side).
- (2) Medical justification for prosthesis.
- (3) Medicare functional classification level (K-level).
- (4) Purpose of limb (every day, activity specific, spare).
- (5) Socket type and shape.
- (6) Interface and suspension type.
- (7) Pylon/shank (including shock absorption/rotators if needed).
- (8) Knee componentry (if transfemoral amputation).
- (9) Hip componentry (if hip disarticulation or hemipelvectomy).
- (10) Foot/ankle componentry.

c. The prescription for an upper limb prosthesis should include the following:

- (1) Diagnosis (includes level of amputation and side).
- (2) Medical justification for prosthesis.
- (3) Purpose of limb (every day, activity specific, spare).
- (4) Socket type and shape.

- (5) Interface and suspension type.
- (6) Control system (i.e., body-powered, myoelectric, passive).
- (7) Harness system.
- (8) Shoulder, elbow, or wrist componentry.
- (9) Terminal device(s).

d. At the time of the Outpatient Amputation Specialty Clinic evaluation, the medical findings and recommendations of the clinic team, including the specific component prescription for a prosthesis or major repair, should be included in the Veteran's medical record.

e. If, prior to prescription of the prosthesis, additional treatment is indicated, the provision of the prosthesis can be deferred pending treatment outcome.

f. Prosthetic training by physical therapy, occupational therapy or kinesiotherapy should be offered at the time of delivery of an initial prosthesis, or a new prosthesis with markedly different componentry than the Veteran's existing device, (i.e., change from mechanical stance control knee to microprocessor for lower extremity prostheses or change from body-powered to myoelectric for upper extremity prostheses). This ensures closer monitoring of tolerance to the new componentry and ambulation, and ADL training with the device. When appropriate, the Veteran's prosthetist should be available during training to make necessary adjustments to the device (e.g., alignment, socket fit, programming adjustments).

g. Prosthetic checkout by a core member of the Outpatient Amputation Specialty Clinic team is strongly recommended for new complete prostheses and socket replacement prescriptions. Additionally, when substantial changes have been made to the prosthesis, such as the prescription of a new type of prosthetic component, it is recommended that checkout of the new component be performed. Prosthesis checkout can be recommended by the clinic team in other circumstances as clinically indicated.

(1) The prosthetic checkout and associated documentation should evaluate and document the following:

- (a) The prosthesis provided matches the Department of Veterans Affairs (VA) prescription and coding.
- (b) The prosthesis is of acceptable fit and function for the Veteran with limb loss.
- (c) The device and workmanship are free of defect.

(2) Checkout completion can occur via telephone, telehealth visits, or in-person visits as clinically appropriate.

OUTPATIENT TELEAMPUTATION CARE SPECIALTY CLINIC SERVICES

1. OVERVIEW

TeleAmputation Care services provide Veterans living with limb loss access to clinical services provided by the VA amputation specialty care team. TeleAmputation Care services must be offered with the benefits of the Veteran in mind and utilized when the quality of care is equal to that of an in-person appointment. These services provide Veterans with the opportunity to receive amputation specialty services using telehealth at a local VA clinic site, in the Veteran's own home or in the office of a community prosthetic provider (CPP). Telehealth can also bridge the gap between two Department of Veterans Affairs (VA) sites in order to provide opportunities for consultative services to smaller facilities without specialized amputation care services. For additional resources as they pertain to the provision of telehealth services, see <http://vaww.telehealth.va.gov/index.asp>. **NOTE:** *This is an internal VA website not available to the public.* The benefits of telehealth care for an Outpatient Amputation Specialty Clinic extend beyond convenience to the Veteran. Some other benefits include:

- a. Ease of access to care for those Veterans with mobility impairments.
- b. Avoiding challenges of transportation for the Veteran with mobility impairments on the caregiver or family.
- c. Minimizing the cost of travel.
- d. Minimizing time away from work for those Veterans still working.
- e. Provision of specialty care, especially for those living in more rural areas.
- f. Enhanced care coordination ensuring a continuum of care.

2. TYPES OF TELEAMPUTATION CARE SPECIALTY CLINICS

The standard set up for a TeleAmputation Care Specialty Clinic visit is that of an interdisciplinary team comprised of a physician, therapist or Amputation Rehabilitation Coordinator (ARC), and a prosthetist. Depending on the identified needs of the Veteran, other providers and support personnel may be incorporated into the telehealth visit. Other potential clinical team member disciplines include, but are not limited to Social Work, Nursing, Wound Care, Surgery, Podiatry, Vocational Counseling and Mental Health. Additional non-clinical team members include Prosthetic Representatives. When appropriate and necessary to complete the team, member(s) of the team may participate in the following ways:

- a. Clinical Video Telehealth (CVT) appointments occur when a telehealth visit occurs

using video conference equipment and the patient and provider are both located at collaborating but different VA locations. This can be from a VA medical facility to a Community Based Outpatient Center (CBOC) or similar satellite location to a medical facility or from one VA medical facility to another VA medical facility.

b. VA Video Connect (VVC) appointments are appointments in which the Veteran accesses the Virtual Medical Room (VMR) from home or any other community setting using a link sent by email.

3. TELEAMPUTATION CARE CLINIC SETUP

To implement TeleRehabilitation Care, individual VA medical facilities must follow the following steps:

a. Initiate the creation of the TeleAmputation Care Specialty Clinic by contacting the VA medical facility Telehealth Coordinator (FTC) for clinic set up requirements.

b. Establish a Telehealth Service Agreement (TSA) that specifies and governs the clinical, business and technical details of operations of the telehealth services between receiving and providing facilities. The TSA defines the responsibilities and procedures involved in establishing and operating a telehealth clinic between the involved medical facility or the involved CPP site.

c. Set up the TeleAmputation Care Specialty Clinic using the correct stop code assignments as this will ensure proper workload credit is reflected for accurate data analysis.

(1) **Primary Stop Code.** Same codes as used for face-to-face care.

(a) 211 - Rehabilitation Amputation Clinic.

(2) **Secondary Stop Codes.** Identifies the location of the Veteran during the visit.

(a) CVT. (Two clinics are required for this set up: one for the provider and one for the VA location where the veteran is located).

1. 690 – VA site, Veteran location during CVT only.

2. 692 – VA site, provider location is *same* VA station number (e.g., CBOC).

3. 693 – VA site, provider location is *different* VA station number (e.g., VA medical facility to VA medical facility).

(b) VVC. (Only one clinic needed).

1. 179 – Veteran’s home.

2. 648 – CPP site.

4. TELEHEALTH VISIT INTEGRATION

Establishing how the TeleAmputation Care Specialty Clinic will be integrated into the clinic schedule fosters a continuum of care for Veterans living with limb loss. A clinic can choose to integrate the telehealth visits within an in-person clinic or choose to have a clinic comprised of only telehealth care appointments. TeleAmputation Care Specialty Clinics can be used for:

- a. Annual follow up to address supply needs, durable medical equipment needs and well-being check-ins.
- b. Prosthetic Checkout to assure that the prosthesis meets the expectations of the Outpatient Amputation Specialty Clinic Team and the Veteran.
- c. Follow up to assess efficacy and completion of prior requests for adjustments or modifications to a prosthesis as well as after supplies have been received; may occur at CPP office.

5. VISIT SETTING

The physical environment is an important aspect of the care experience. It is critical to ensure a safe environment during the clinic visit.

a. If the Veteran is located in a VA site and will be seen virtually, it is important that the clinical setting at the site allows for the following:

- (1) Privacy for the Veteran to don and doff the prosthesis and involved clothing.
- (2) Adequate ambulation space (minimum of 20 feet) for gait evaluations that can be viewed from the telehealth video equipment and is free of obstacles.
- (3) If possible, the telehealth equipment should be in a clinical setting, where the use of such equipment (e.g., parallel bars, a mat table and an exam table) can be viewed.
- (4) Adequate room for the Veteran, family and all necessary team members.

b. If at the Veteran's home or other community location, it is important to ensure the following as it pertains to the home setting:

- (1) Adequate ambulation space (minimum of 20 feet) for gait evaluation that can be viewed on the personal device.
- (2) The space within the home must be free of obstacles.
- (3) Adequate room for Veteran, family and all necessary team members.
- (4) Free of distraction and excess noise to optimize the telehealth experience.

6. DOCUMENTATION

Documentation of the visit must include the following details:

- a. Verbal consent from the Veteran to participate in the TeleAmputation Care Specialty clinic.
- b. The address and physical location of the Veteran at that address.
- c. The phone number of the Veteran.
- d. A statement addressing the environment and safety of that environment for participation in the visit.
- e. A full explanation of telehealth, alternatives for care through an in-person visit at the nearest VA clinic site and the Veteran's right to refuse participation in TeleRehabilitation Care at any time.
- f. Complete evaluation performed during visit.
- g. Summary of findings.
- h. Clinical recommendations and treatment options.
- i. Follow up plan.