# PHYSICAL MEDICINE AND REHABILITATION SERVICE

**1. SUMMARY OF MAJOR CHANGES:** This directive:

a. Updates procedures and requirements for Physical Medicine and Rehabilitation Services (PM&RS) across the continuum of care.

b. Adds direct access guidance for PM&RS.

c. Updates responsibilities in paragraph 2 for the Executive Director, Veterans Health Administration (VHA) Rehabilitation and Prosthetic Services, Executive Director, PM&RS, Department of Veterans Affairs (VA) PM&RS Chief or Service Line Manager, and VA medical facility Interdisciplinary Team Lead to incorporate mandatory responsibilities previously specified in the appendices.

d. Requires all inpatient rehabilitation bed units meet Commission on Accreditation for Rehabilitation Facilities (CARF) accreditation standards if the average daily census is equal to ten inpatient rehabilitation beds, regardless of location within the VA medical facility.

e. Moved information from previous appendices C-G to the PM&RS SharePoint. See "Additional Resources" available at: https://dvagov.sharepoint.com/sites/vhasitespmrs/SitePages/PM%26RS-Directives-and-Policies.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

**2. RELATED ISSUES:** VHA Directive 1040, Water Safety Certification Requirements for Therapeutic and Recreational Swimming Pool Staff, dated May 4, 2020; VHA Directive 1170.01, Accreditation of VHA Rehabilitation Services, dated September 23, 2022; VHA Directive 1170.02(1), VHA Audiology and Speech-Language Pathology Services, dated December 9, 2020; VHA Directive 1170.05, Physical Therapy Practice, dated September 16, 2024; VHA Directive 1170.06(1), Occupational Therapy Services, dated June 24, 2024; VHA Directive 1172.01, Polytrauma System of Care, dated April 18, 2024; VHA Directive 1172.03, Amputation System of Care, dated December 19, 2023; VHA Directive 1172.05, Recreation Therapy and Creative Arts Therapy Service, dated September 7, 2022; VHA Directive 1173.16, Driver Rehabilitation for Veterans Program, dated June 28, 2023; and VHA Directive 1900(5), VA National Standards of Practice, dated August 30, 2023.

**3. POLICY OWNER:** The Executive Director, Rehabilitation and Prosthetic Services (12RPS) is responsible for the contents of this directive. Questions may be referred to the Executive Director, PM&RS at: VHAPMRSProgramOfficeHelp@va.gov.

**4. LOCAL DOCUMENT REQUIREMENTS:** There are no local document creation requirements in this directive.

**5. RESCISSIONS:** VHA Directive 1170.03(1), Physical Medicine and Rehabilitation Services, dated November 5, 2019, is rescinded.

**6. RECERTIFICATION:** This Veterans Health Administration (VHA) directive is scheduled for recertification on or before the last working day of November 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**7. IMPLEMENTATION SCHEDULE:** This directive is effective 3 months from date of publication.

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

/s/ M. Christopher Saslo
DNS, ARNP-BC, FAANP
Assistant Under Secretary for Health
for Patient Care Services/CNO

***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 22, 2024.

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## PHYSICAL MEDICINE AND REHABILITATION SERVICE

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## 1. POLICY

It is Veterans Health Administration (VHA) policy that all Veterans eligible for Department of Veterans Affairs (VA) health care services and active duty Service members eligible for VA health 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 individualized care and contractual arrangements for community care.* **AUTHORITY:** 38 U.S.C. §§ 1706(b), 1710, 1710(A), 1782, and 7301(b).

## 2. 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/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for

(1) Supporting the Office for Rehabilitation and Prosthetic Services with implementation and oversight of this directive.

(2) Supporting the development of mitigation or corrective actions to address noncompliance with this directive.

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 Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Overseeing VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Rehabilitation and Prosthetic Services.** The Executive Director, Rehabilitation and Prosthetic Services is responsible for:

(1) Overseeing and ensuring that corrective action is taken when non-compliance is identified.

(2) Reviewing and collaborating with the Executive Director, Physical Medicine and Rehabilitation Service (PM&RS) on proposed changes to PM&RS policies, including VHA Directive 1040, Water Safety Certification Requirements for Therapeutic and Recreational Swimming Pool Staff, dated May 4, 2020; VHA Directive 1170.05, Physical

Therapy Practice, dated September 16, 2024; VHA Directive 1172.01, Polytrauma System of Care, dated April 18, 2024; VHA Directive 1172.03, VHA Amputation System of Care, dated December 19, 2023; VHA Directive 1170.06(1), Occupational Therapy Services, dated June 24, 2024; VHA Directive 1173.3, VHA Outpatient Amputation Specialty Clinics, dated March 8, 2021; VHA Directive 1173.16, Driver Rehabilitation for Veterans Program, dated June 28, 2023; and VHA Directive 1184, Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury (TBI), dated January 3, 2022.

(3) Communicating programmatic changes to PM&RS to the Assistant Under Secretary for Health for Patient Care Services/CNO.

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

(1) Ensuring development and maintenance of this directive and related programmatic standards for PM&RS outlined in Appendix A and B.

(2) Providing guidance to VISNs and VA medical facilities for the development and operation of PM&RS upon request from VISN Directors, VA medical facility Directors, or VA medical facility PM&RS Chiefs or Service Line Managers.

(3) Designating specific PM&RS programs required to obtain and maintain Commission on Accreditation for Rehabilitation Facilities (CARF) accreditation, which includes initial CARF accreditation, survey extensions, and appropriate approval of CARF contracting and invoicing. ***NOTE:*** *For more information on CARF accreditation, see Appendices A and B in this directive and VHA Directive 1170.01, Accreditation of VHA Rehabilitation Programs, dated September 23, 2022.*

(4) Reviewing and approving all PM&RS bed change requests and policy waivers submitted by the VISN Director (see VHA Directive 1023Thi, Waivers to VHA National Policy, dated March 5, 2024), then communicating these approvals or denials through interoffice routing to the Executive Director, Rehabilitation and Prosthetic Services, along with providing recommendations on staffing and number of rehabilitation beds to VISN and VA medical facility leadership (e.g., VISN and VA medical facility Directors, Chiefs of Staff (COS), Chief Medical Officers, CNOs, and Associate Directors of Patient Care Services) and VA medical facility PM&RS Chiefs or Service Line Managers. ***NOTE:*** *Inpatient rehabilitation bed units must meet CARF accreditation standards if the average daily census is equal to ten inpatient rehabilitation beds, regardless of location within the VA medical facility, including treating specialty codes 20 and 64. For more information on bed change requests, see VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017, and VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010. For further information on CARF accreditation, see VHA Directive 1170.01.*

(5) Consulting with VA medical facilities on accreditation standards for physical medicine and rehabilitative services.

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

(7) Collaborating with the Executive Director, Rehabilitation and Prosthetic Services on proposed changes to PM&RS policies including VHA Directive 1040, VHA Directive 1170.05, VHA Directive 1170.06(1), VHA Directive 1172.01, VHA Directive 1172.03, VHA Directive 1173.3, VHA Directive 1173.16, and VHA Directive 1184.

(8) Monitoring VA medical facilities to ensure alignment with CARF accreditation.

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

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing the Assistant Under Secretary for Health for Patient Care Services and the Assistant Under Secretary for Health for Operations when barriers to compliance are identified.

(2) Establishing oversight of corrective actions addressing operational noncompliance at the VISN or VA medical facility level when indicated.

(3) Ensuring VA medical facilities meet accreditation standards for physical medicine and rehabilitative services.

(4) Ensuring that PM&RS are accessible to eligible Veterans and active duty Service members covered by TRICARE. ***NOTE:*** *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 patients treated within a VISN*.

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

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

(2) Ensuring appropriate staffing and clinical expertise, to provide rehabilitation services within the VA medical facility. For more information on staffing requirements, see VHA Directive 1172.01 and VHA Directive 1173.3.

(3) Ensuring that the VA medical facility's PM&RS clinics meet the requirements of the Americans with Disabilities Act (ADA) of 1990 and ADA Amendments Act of 2008 (42 U.S.C. Chapter 126).

(4) Supporting local PM&RS staff providing public information services, educational programs, and presentations designed to promote the benefits of PM&RS.

(5) Ensuring that no proposed organizational change in a rehabilitation bed unit is implemented at the VA medical facility without prior approval of the Executive Director, PM&RS. ***NOTE:*** *For additional information, see VHA Directive 1002 and VHA Handbook 1000.01*.

(6) Collaborating with the VA medical facility PM&RS Chief or Service Line Manager 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 discipline-specific therapy supervisor or lead for hiring, recruitment, scope of practice, and competency assessment. In VA medical facilities that have service line organization, therapies may be supervised by a Physical Therapy (PT), Kinesiotherapy (KT), or Occupational Therapy (OT) program or clinical manager.*

(7) Ensuring that the VA medical facility PM&RS Chief or Service Line Manager designates at least one member representing PM&RS on VA medical facility-wide committees for which PM&RS has relevant clinical interest (e.g., medical equipment committee, resource management committee and medical staff committee).

(8) Ensuring that all rehabilitation beds are co-located in the same designated area, and treatment areas provide opportunities for patients to interact with each other as part of the rehabilitation process.

(9) Designating bed units as rehabilitation inpatient units at the VA medical facility and analyzing demand on an annual basis. ***NOTE:*** *If the average daily census is equal to ten inpatient rehabilitation beds, the unit needs to be CARF accredited. See paragraph 2.e. and VHA Directive 1170.01.*

h. **VA Medical Facility Physical Medicine and Rehabilitation Service Chief or Service Line Manager.** The VA medical facility PM&RS Chief or Service Line Manager is responsible for:

(1) Having a working knowledge of the principles of interdisciplinary rehabilitation to communicate pertinent patient care and service delivery issues to senior leaders (e.g., Executive Director, PM&RS, VA medical facility Director, VA medical facility COS) and VA medical facility PM&RS staff.

(2) Ensuring compliance with programmatic standards established within this directive.

(3) Ensuring the development and implementation of annual VA medical facility PM&RS service delivery plans.

(4) Gathering stakeholder feedback and input from patients and all levels of personnel (e.g., PM&RS and related disciplines) and incorporating any necessary quality of care and service delivery enhancements or staff engagement recommendations identified within stated feedback into the annual VA medical facility PM&RS service delivery plans as appropriate.

(5) Collaborating with the VA medical facility Director to determine the most appropriate supervision and leadership of therapy disciplines, and establishing a lead or senior therapist, in instances when PT, KT, and OT is not supervised by a person credentialed in the 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) Sharing best practices and staff development opportunities including professional training programs, encouraging continuing education, and providing rewards and recognition.

(7) Recommending to the VA medical facility Director projected staffing needs, equipment, and supply management, and other aspects of administering and managing PM&RS. ***NOTE:*** *Any such recommendations must be based on information and data the VA medical facility PM&RS Chief or Service Line Manager is monitoring. See paragraph 2.h.(11) below.*

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

(9) Determining admission criteria for the Comprehensive Inpatient Rehabilitation Program (CIIRP) program based on the criteria in Appendix A, paragraph 2.b.(2).

(10) Ensuring appropriate PM&RS orientation is provided to all patients admitted to the inpatient rehabilitation unit, as well as to the patients' family members and caregivers. ***NOTE:*** *Rehabilitation orientation information must be given to each patient upon admission. The orientation must include what services the patient will receive and predicted outcomes.*

(11) Monitoring outcomes and designating at least one person to coordinate the administration of the rehabilitation outcome tools data management for patient and programmatic outcomes and identify process improvement opportunities. ***NOTE:*** *A rehabilitation manager, therapist, case manager, or quality management person actively involved in rehabilitation care management is best suited for this role. For further information, see "Outcomes for Inpatient Rehabilitation Units" guidance available at: https://dvagov.sharepoint.com/sites/vhasitespmrs/SiteAssets/Forms/AllItems.aspx?id=%2Fsites%2Fvhasitespmrs%2FSiteAssets%2FSitePages%2FPM%26RS%2DDirectives%2Dand%2DPolicies&viewid=3c4ca7fd%2D5813%2D4317%2D8ccf%2D33948a06b7bd.* ***NOTE:*** *This is an internal VA website that is not available to the public.*

(12) Ensuring PM&RS staff meet and maintain competency and continuing education requirements to maintain current licensure, registration, and certification status.

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

(14) Maintaining regular contact with and disseminating information from the national PM&RS program office to all local rehabilitation personnel at their VA medical facility.

(15) Designating at least one person to represent PM&RS on VA medical facility-wide committees pertinent to PM&RS (e.g., medical staff committee, medical equipment committee and resource management committee).

(16) Establishing the VA medical facility rehabilitation Interdisciplinary Teams (IDTs) for patients admitted to an inpatient rehabilitation bed unit and designating a lead as a collateral duty among VA medical facility PM&RS medical staff (i.e., not a stand-alone position for the inpatient rehabilitation bed unit). ***NOTE:*** *IDTs are led by a board-certified or board-eligible attending physiatrist, physician, a PM&RS physician resident, physician assistant (PA), nurse practitioner (NP), or other credentialed or privileged health care provider with extensive rehabilitation experience. Physician residents may serve as IDT lead with proper supervision as detailed in VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.*

(17) Designating an individual within PM&RS (e.g., nurse manager, case manager, physician, rehabilitation therapist, or social worker) to ensure that referrals for admission for acute inpatient rehabilitation services or CIIRP are coordinated with the referral source, the patient, their caregiver, the patient's family, and the rehabilitation IDT. See paragraph 3 for additional details.

(18) Ensuring that an individualized plan of care with treatment goals and discharge planning is developed by an IDT in conjunction with the patient's medical team in accordance with Appendix B as well as obtaining consent for treatments and procedures. For further information, see VHA Directive 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.

(19) Ensuring that patients are scheduled for inpatient or outpatient treatment at an established frequency and for an established duration. ***NOTE:*** *When a response to treatment is not predictable, a trial of rehabilitation therapy may be recommended by the rehabilitation provider who performed the evaluation.*

i. **VA Medical Facility Inpatient Rehabilitation Interdisciplinary Team Lead.** ***NOTE:*** *The VA medical facility PM&RS Chief or Service Line Manager establishes the rehabilitation IDT and designates the lead as a collateral duty among PM&RS medical staff (i.e., not a stand alone position for the inpatient rehabilitation bed unit). The inpatient rehabilitation IDT is overseen by a board-certified or board-eligible physician, physiatrist, a PM&RS physician resident, PA, NP, or a credentialed or privileged health care provider. Disciplines represented on the rehabilitation IDT may include but are not limited to Physiatry, Geriatrics and Extended Care, Women's Health, Primary Care, Rehabilitation Nursing, Rehabilitation Case Management, OT, PT, KT, Recreation Therapy/Creative Arts Therapy, Speech Language Pathology, Vocational Rehabilitation, Psychology, Audiology, Chiropractic, Blind Rehabilitation Therapy, Dental, Optometry, Ophthalmology, Clinical Pharmacy Specialist, Social Work, and Nutrition. Other*

*disciplines may be consulted as determined by the patient's needs.* The VA medical facility inpatient rehabilitation IDT, including a Community Living Center (CLC) IDT, Lead is responsible for:

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

(2) Developing an individualized plan of care with goals and timeframes established and monitors clinical outcomes on a routine basis. ***NOTE:*** *The plan of care is patient-centered, based on active involvement of the patient, family, and IDT members or other support system participants identified by the patient and IDT. See Appendix B for further information.*

(3) Ensuring that the plan of care is documented in the electronic health record (EHR). ***NOTE:*** *Any changes to the plan, made by either the IDT or the patient, are communicated automatically to the IDT by updating the EHR.*

(4) Ensuring that plans of care for patients requiring intervention from CLCs are integrated into the CLC plan of care so there is one plan for the patient and IDT to follow. See Appendix B for additional information.

(5) Ensuring that rehabilitation IDT members provide the patient and their caregivers with appropriate education and training as necessary throughout the rehabilitation process to become knowledgeable of the patient's condition and treatment needs and to learn skills and behaviors that promote the patient's recovery and improve function. See Appendix B for further information on types of instruction. ***NOTE:*** *Assessment of learning needs, abilities, and readiness to learn must be performed by each IDT member and documented in discipline-specific progress notes in the EHR.*

(6) Ensuring that the physiatrist, physician, or a credentialed or privileged physician, or a credentialed or privileged health care provider with extensive rehabilitation experience assigned to the IDT oversees the plan of care and designates a point of contact to communicate the plan of care to the patient.

(7) Ensuring that during the IDT meeting, in order to measure the patient's progress, the appropriate member of the IDT reviews the patient's response to the interventions outlined in the plan of care, changes in the patient's condition, choices for alternative interventions, and progress towards meeting the established goals. ***NOTE:*** *The notes from IDT meetings must address the progress made and specify any new or modified interventions needed prior to discharge. The first IDT meeting must be with the patient and their caregiver (if available), and any changes or recertifications of the plan of care must be communicated to the patient and their caregiver (if available) thereafter. See Appendix B for further information.*

(8) Ensuring that progress reports are entered into the patient's EHR by each member of the IDT to reflect the patient's condition and progress towards the patient's rehabilitation goals. ***NOTE:*** *Documentation frequency must meet the standard set in the*

*VA medical facility's PM&RS procedures, which must be in accordance with the accrediting agency requirements for the VA medical facility.*

(9) Designating an IDT member to enter a written progress note in the EHR following the family conference, outlining the purpose of the conference, the participants, and the outcome.

(10) Ensuring that all IDT members complete a discharge summary relevant to their discipline's scope of practice. See Appendix B, paragraph 2.e. for further information.

(11) Delivering inpatient rehabilitation services within each IDT member's scope and standards of practice and ensuring that follow-up or after care is planned for and provided by the IDT members while the patient is an inpatient and documented in the discharge summary. ***NOTE:*** *The continuum of rehabilitation services provided to the patient is determined by the patient's rehabilitative needs and not by the rehabilitation unit location or designation*.

(12) Ensuring that the social worker assigned to the IDT works with the patient and their caregiver to resolve issues regarding housing, residential care, financial support, home care, and others personal to the patient to ensure continued recovery or maintenance after discharge.

(13) Delivering the rehabilitation continuum of care standards, including the CIIRP, in accordance with Appendix A.

## 3. PHYSICAL MEDICINE AND REHABILITATION SERVICES

a. Any patient may demonstrate a need for rehabilitation services to improve their functional status, chronic pain management, and quality of life. 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, including but not limited to outpatient PT, OT, wheeled mobility, amputation and Be Active and MOVE! clinics, the patient can make a scheduled appointment directly with PM&RS without a referral from a health care provider. This is referred to as patient self-referral direct schedule and direct access. In direct access clinics, consultative action is not required, unless the PT, OT, or KT determine that the patient's credentialed or privileged health care provider must provide medical clearance prior to proceeding with a therapy evaluation. ***NOTE:*** *See VHA Directive 1170.05, VHA Directive 1170.06(1), and VHA Directive 1900(5), VA National Standards of Practice, dated August 30, 2023, for additional information on direct referral and direct access.*

c. Some PM&RS clinics have open access without a requirement for a patient to have a scheduled appointment and are referred to as walk-in clinics. Examples of walk-in clinics include but are not limited to issuing durable medical equipment, canes, crutches, and walkers; health coaching; and pre-operative instructions.

d. For all referrals for admission for acute inpatient rehabilitation services or CIIRP, a designated person such as a nurse manager, case manager, a credentialed or privileged health care provider, rehabilitation therapist, or social worker must coordinate the admission with the referral source, the patient, caregiver, the patient's family, and the rehabilitation IDT.

e. Regardless of the origin of the inpatient rehabilitation referral, once a consult to a rehabilitation program is initiated, the patient must be screened by the rehabilitation IDT to develop an appropriate plan of care based on the patient's rehabilitation needs.

f. Inpatient medical rehabilitation may be provided by a number of rehabilitation clinicians. Physiatrists, Physical Medicine and Rehabilitation trained physicians, lead the medical rehabilitation team and provide comprehensive neurologic and musculoskeletal treatment.

g. The VA medical facility PM&RS Chief or Service Line Managers 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.*

## 4. OVERSIGHT AND ACCOUNTABILITY

a. **Internal Controls.** The internal controls in this directive are:

(1) Leadership oversight as outlined in paragraph 2 of this directive.

(2) Executive Director, PM&RS: Approving any proposed organizational change in a rehabilitation bed unit.

(3) VA medical facility PM&RS Chief or Service Line Manager: Designating at least one individual to represent PM&RS on VA medical facility-wide committees (e.g., medical equipment committee, resource management committee, and medical staff committee) and at least one person to coordinate the administration of rehabilitation outcome tools, data entry, and management of the VA medical facility's data.

b. **Metrics.** The metrics in this directive that assess the directive or program effectiveness are:

(1) Ongoing monitoring of VA medical facilities to ensure compliance and alignment with CARF accreditation by the Executive Director, PM&RS.

(2) Ongoing monitoring of outcomes for inpatient rehabilitation units by the VA medical facility PM&RS Chief or Service Line Manager (see paragraph 2.h.(11)).

## 5. TRAINING

There are no formal training requirements associated with this directive.

## 6. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive shall be managed as required by 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 can be addressed to the appropriate Records Manager or Records Liaison.

## 7. REFERENCES

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

b. 42 U.S.C. Chapter 126.

c. 38 C.F.R. § 17.419.

d. VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.

e. VHA Directive 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated December 12, 2023.

f. VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.

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

h. VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.

i. VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated September 23, 2022.

j. VHA Directive 1170.05, Physical Therapy Practice, dated September 16, 2024.

k. VHA Directive 1170.06(1), Occupational Therapy Services, dated June 24, 2024.

l. VHA Directive 1172.01, Polytrauma System of Care, dated April 18, 2024.

m. VHA Directive 1172.03, VHA Amputation System of Care, dated December 19, 2023.

n. VHA Directive 1172.05, Recreation Therapy and Creative Arts Therapy Service, dated September 7, 2022.

o. VHA Directive 1173.3, VHA Outpatient Amputation Specialty Clinics, March 8, 2021.

p. VHA Directive1173.16, Driver Rehabilitation for Veterans Program, dated June 28, 2023.

q. VHA Directive 1184, Screening and Evaluation of Post-9/11 Veterans for Deployment-Related Traumatic Brain Injury (TBI), dated January 3, 2022.

r. VHA Directive 1400.01 Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

s. VHA Directive 1900(5), VA National Standards of Practice, dated August 30, 2023.

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

u. Outcomes for Inpatient Rehabilitation Units. https://dvagov.sharepoint.com/sites/vhasitespmrs/SiteAssets/Forms/AllItems.aspx?id=%2Fsites%2Fvhasitespmrs%2FSiteAssets%2FSitePages%2FPM%26RS%2DDirectives%2Dand%2DPolicies&viewid=3c4ca7fd%2D5813%2D4317%2D8ccf%2D33948a06b7bd. ***NOTE:*** *This is an internal VA website that is not available to the public.*

v. Claims and Reimbursement for Therapy Services. Chapter 7 Section C. Rehabilitation Therapies Reasonable Charges and Billing Procedures. https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. ***NOTE:*** *This is an internal VA website that is not available to the public.*

w. Telehealth Rehabilitation & Prosthetic Services: http://vaww.telehealth.va.gov/clinic/rehab/trehb/index.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

x. 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/554400000001031/content/554400000050097/Section-A-Kinesiotherapy-Coverage-and-Billing-Requirements. ***NOTE:*** *This is an internal VA website that is not available to the public.*

y. CARF Guidance and Resources. https://vaww.qps.med.va.gov/divisions/qm/ea/CARF.aspx. ***NOTE:*** *This is an internal VA website 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. Any Veterans Health Administration (VHA) bed unit designated by the Department of Veterans Affairs (VA) medical facility Director as a rehabilitation inpatient unit, if the average daily census is equal to ten inpatient rehabilitation beds, regardless of location within the VA medical facility including Treating Specialty Code 20 and 64, must earn and maintain Commission on Accreditation for Rehabilitation Facilities (CARF) Accreditation. A list of CARF-accredited programs is provided for reference by the VHA Office of Quality and Patient Safety, External Accreditation Services & Programs, accessible at: https://vaww.qps.med.va.gov/divisions/qm/ea/CARF.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

## 2. CORE LEVELS OF CARE

a. The continuum of rehabilitation services provided to the patient is determined by the VA medical facility rehabilitation interdisciplinary team (IDT) and by the patient'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 patients 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 appropriately 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 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:*** *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), recreation therapy (RT)/creative arts therapy (CAT), and speech-language pathology (SLP), if their approved scope of practice at the VA medical facility permits.*

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

(2) **Comprehensive Integrated Inpatient Rehabilitation Program.**

(a) The Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) (i.e., Inpatient Rehabilitation Bed Services) provides a patient-centered, coordinated, and intensive program of integrated medical and rehabilitation services delivered by the IDT that may include, but is not limited to: physiatry, rehabilitation nursing, rehabilitation case management, OT, PT, KT, SLP, RT/CAT, clinical social work, and psychology. The IDT supports and reinforces each patient's individual plan of care 24 hours a day, 7 days a week for those medically stable who require and can tolerate intensive rehabilitation services. Intensity and duration of therapy is individual to the patient, but often includes three hours of treatment comprised of two or more rehabilitation goal-oriented therapies per day (e.g., OT, PT, KT, SLP, and RT/CAT). ***NOTE:*** *For more information, see VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated September 23, 2022*.

(b) Inpatient rehabilitation bed units must earn accreditation from CARF. Regardless of the location, if an inpatient bed section's function is designated as comprehensive inpatient rehabilitation and has an average daily census equal to or greater than ten inpatient rehabilitation beds, the inpatient rehabilitation bed unit is required to be accredited by CARF. The VA medical facility PM&RS Chief or Service Line Manager ensures that accreditation is earned by coordinating with the accrediting officials.

(c) Rehabilitation beds must all be located in the same designated area, and treatment areas must provide opportunities for patients 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. The IDT and the patient identify goals for mobility, activities of daily living, instrumental activities of daily living, 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 training in life skills. Treatment interventions are individualized incorporating patient and caregiver education and preparation for the patient's transition back into the community. Patients 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 patient would be better served by another program within the continuum of care.

(e) Each CIIRP program has admission criteria and an admission screening process. This level of care is appropriate for patients 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 VA medical facility PM&RS Chief or Service Line Manager. Patients are admitted from various sources, including the same VA medical facility, another VA medical facility, military treatment facilities, community care, and home.* ***NOTE:*** *Some programs may offer short-stay evaluations to determine ongoing care needs, but this is not a requirement.*

(3) **Outpatient Medical Rehabilitation.**

(a) Outpatient medical rehabilitation may be provided by a number of rehabilitation clinicians. Physiatrists, Physical Medicine and Rehabilitation trained physicians, lead the medical rehabilitation team and provide comprehensive neurologic and musculoskeletal treatment.

(b) Outpatient medical rehabilitation must be considered when a patient has functional limitations and quality of life needs requiring skilled intervention by rehabilitation therapists, but inpatient medical care is not necessary. Other specific needs for outpatient rehabilitation may include but not limited to musculoskeletal medicine, chronic pain management, botulinum toxin treatment for migraine, complimentary integrative health interventions (acupuncture), and other joint injections ultrasound-guided or not, that occur on the outpatient setting only. The expectation is that the patient's condition will improve in a reasonable and generally predictable period, or the services provided in outpatient rehabilitation are necessary for improving quality of life or establishing a safe and effective environment. Outpatient rehabilitation services may be provided in the outpatient therapy department, the community, or the patient's home. Treatment plans and goals must be communicated by the physiatrist or therapist(s) to the patient's primary care team, either in the community or the VA Patient-Aligned Care Team.

(c) Referrals for outpatient rehabilitation services are generated by various sources (e.g., primary care physicians, neurosurgeons, plastic surgeons, physiatrists, chiropractors, acupuncturists) and medical subspecialties such as orthopedics, rheumatology and neurology, inpatient attending physicians, VA community providers, or advanced practice provider.

(d) Within certain practice settings, patients may have direct access to physical therapy services and occupational therapy services without a credentialed or privileged health care provider's consult in accordance with state licensure. (See VHA Directive 1170.05, Physical Therapy Practice, dated September 16, 2024, and VHA Directive 1170.06(1) Occupational Therapy Services, dated June 24, 2024, for detailed information on direct scheduling.) The Council on Professional Standards for Kinesiotherapy, Inc. approved KT Scope of Practice permits KT treatments to be initiated without direct referral within VA so long as the subsequent treatment plan is reviewed by a physician, PA, or NP and there is evidence of continued care by the patient's primary care provider; and specifically permits KT treatment interventions for wellness through direct access (See VHA Directive 1900(5), VA National Standards of Practice, dated August 30, 2023).

(e) Following the initial therapy or IDT assessment, the patient must 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 patient will improve from therapeutic intervention and that the patient 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.

(f) During outpatient care, PM&RS rehabilitation specialists may determine that additional services are needed, such as psychological, psychiatric, psychopharmacological, or other medical subspecialty consultation.

(4) **Transitional Rehabilitation.**

(a) Transitional rehabilitation is suitable for Veterans and active duty Service members with Amputation, Polytrauma or TBI who have physical, cognitive, or behavioral difficulties that persist after the acute phase of rehabilitation and prevent them 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 April 18, 2024

(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 patient and are indicated by Treating Specialty Code 20 and 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.

(7) **Telerehabilitation and Virtual Rehabilitation Care.**

(a) Telerehabilitation services can be used to increase access to outpatient specialty rehabilitation care. These services allow the VA health care provider to be located at a tertiary VA medical facility while the patient is at a community-based outpatient clinic or at home. ***NOTE:*** *For more information on telerehabilitation applications and toolkits, see: http://vaww.telehealth.va.gov/clinic/rehab/trehb/index.asp. This is an internal VA website that is not available to the public.*

(b) Patients in rural areas, can greatly benefit from telerehabilitation. Many of these patients have mobility issues or socioeconomic factors that affect their ability to receive

needed care. Thus, these patients often have less access to care and possibly decreased quality of care. For patients 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.

# REHABILITATION INTERDISCIPLINARY TEAM PROCEDURES

## 1. ASSESSMENT PROCESS AND DOCUMENTATION

a. A thorough initial assessment is performed by all members of the rehabilitation interdisciplinary team (IDT). This assessment gathers pathophysiological, functional, cognitive, communicative, behavioral and emotional, pharmacological, physical, and social data regarding the patient'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 patient's rehabilitation care needs; and

(2) Enable the IDT to establish the patient's plan of care. Evaluation and treatment are initiated according to the timeframe established in the Department of Veteran's Affairs (VA) medical facility's Physical Medicine and Rehabilitation Service (PM&RS) plan of care.

b. **Rehabilitation Interdisciplinary Team**. Rehabilitation care is patient-centered. The patient's goals must be at the center of the rehabilitation process. Members of the IDT may include an attending physician or physiatrist, a credentialed or privileged health care provider, physical therapist (PT), occupational therapist (OT), kinesiotherapist (KT), recreation therapist/creative arts therapist (RT/CAT), speech and language pathologist, rehabilitation nurse, case manager, social worker, clinical pharmacy specialist, and psychologist. Consultants to the IDT may include but are not limited to an audiologist, blind rehabilitation staff, chiropractor, vocational rehabilitation specialist, chaplain, dietitian, optometrist, podiatrist, prosthetist or orthotist, prosthetic representative, respiratory therapist, medical, surgical, and psychiatric specialists, wound care specialist, peer support groups, educator, and a women's health program or case manager.

## 2. PLAN OF CARE

a. The rehabilitation IDT compiles the assessment information from all IDT members into a single custom plan of care for the patient that identifies the patient's treatment goals and predicted outcomes. The plan of care represents the overall direction that the rehabilitation IDT takes in assisting the patient to achieve improvements in independence, function, and quality of life. ***NOTE:*** *A plan of care can be used for both inpatients and outpatients.*

b. Each member of the rehabilitation IDT evaluates their respective discipline-specific concerns related to the patient's medical and surgical diagnoses, prognosis, impairments and sequelae of the patient. The plan of care synthesizes information gathered from the patient, family and discipline-specific evaluations, allowing for the completion of a functional impairment list, identified interventions, measurable and

expected short-term, long-term and discharge goals, and patient education needs to mitigate identified patient safety concerns. The physiatrist or physician with extensive rehabilitation experience oversees the plan of care. The plan of care and any changes to the plan over time are recorded in the electronic health record (EHR). The physician or a credentialed or privileged health care provider designates a point of contact to communicate the plan of care and any changes to the patient. The plan of care is not intended to replace discipline-specific treatment plans or notes. ***NOTE:*** *For more information, see the Individualized Rehabilitation and Community Reintegration Plan of Care referenced within VHA Directive 1172.01, Polytrauma System of Care, dated April 18, 2024.*

c. For patients living in Community Living Centers (CLCs), the plan of care and IDT meetings guide the clinical process for intervention by the CLC IDT members. The core CLC members include the VA health care provider, registered nurse, nursing assistant, social worker, RT/CAT, and registered dietician. professionals are an integral part of the CLC IDT as well. The plan of care must be integrated into the CLC plan of care which will provide one plan of care for the patient and the IDT to follow.

d. 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 patient's condition. These assessments include specific 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 evaluations are documented in the EHR and communicated to the team and the patient during the IDT meeting. Assessment and re-assessment timeframes are determined within local medical facility procedures.

e. All rehabilitation 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 patient at the time of discharge. The summary must include medications, activity restrictions, adaptive equipment provided, and progress towards rehabilitation goals. Additional discharge information must state the discharge home environment, written instructions provided to the patient and any caregiver, any community contacts, and future appointments to assist with the patient's transition back into the community.

f. For outpatient rehabilitation, a plan of care can also guide the clinical process for patients 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, physician resident, or a credentialed or privileged health care provider. Outpatient rehabilitation IDTs provide individualized, coordinated, and outcome-focused outpatient services, including physiatry services, therapy services, education, and psychological treatment and support to patients 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, a physician resident, or a credentialed or privileged health care provider (if on the team). Treatment interventions are an integration of medical, psychosocial, and functional interventions.

b. Patients receiving comprehensive inpatient rehabilitation on a unit accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or otherwise, receive services and interventions from the rehabilitation IDT, depending on the patient'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 patient is reviewed regularly by the rehabilitation IDT with regard to:

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

(2) Changes in the patient'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 must address the progress made and specify any new or modified interventions needed prior to discharge. ***NOTE:*** *The first IDT meeting is with the patient and caregiver (if available) and any changes and recertification of the treatment plan will be communicated to the patient and caregiver (if available) thereafter.*

## 5. DOCUMENTATION

Progress reports are entered into the patient's EHR by each member of the rehabilitation IDT to reflect the patient's condition and progress towards the rehabilitation goals. Documentation frequency must meet the standard set in the VA medical facility's PM&RS procedures, which must be in accordance with the accrediting agency requirements for the VA medical facility.

## 6. PATIENT AND FAMILY EDUCATION

a. The patient and their family are provided with appropriate education and training by rehabilitation IDT members as necessary throughout the rehabilitation process to

become knowledgeable of the patient's condition and treatment needs and learn skills and behaviors that promote the patient'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 patient's treatment in accordance with 38 U.S.C. § 1782.*

b. Each member of the rehabilitation IDT assesses learning needs, abilities, and readiness to learn and documents the assessment in discipline-specific progress notes.

c. Types of instruction include:

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

(2) Information about how to navigate VHA healthcare services and 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 patient's needs.

## 7. THERAPEUTIC APARTMENT STAY OR THERAPEUTIC HOME PASS

The therapeutic apartment stay or home pass approved by the patient's attending physician or a credentialed or privileged health care provider is designed to help patients and their families apply skills acquired in the inpatient rehabilitation program to their own home setting. A provider order stating the duration and approximate time for the patient to leave and return to the inpatient rehabilitation unit is required for a home pass. The patient or family member must inform the IDT about the outcomes of the stay, both positive and negative, and that information must be incorporated into the patient's plan of care. For more information on authorized absences, passes and campus privileges.

## 8. FAMILY CONFERENCES

a. For the purpose of this directive, the patient's family includes persons living with the patient, or, where the patient is living alone, the patient's emergency contacts. The patient determines who is considered family, and who is appropriate to participate in the family conference, unless the patient 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 the patient's case manager 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 rehabilitation IDT with the family and patient to reach an

understanding of the plan of care. Additionally, education is provided regarding the patient'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 rehabilitation 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 patients 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 rehabilitation IDT based on the patient'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. VA medical facilities must comply with the processes in place for a patient or caregiver to appeal PM&RS providers' medical decision that the patient is not a candidate or is no longer a candidate for rehabilitation services in accordance with VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.

## 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 rehabilitation IDT after the patient is discharged from the inpatient program.

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

c. Prior to discharge, the social worker assigned to the IDT works with the patient and their 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. Rehabilitation IDT members must provide follow-up care and treatment by the designated rehabilitation, as indicated within the discharge summary.

## 11. BILLING, CODING AND BUSINESS RULES

Veterans Health Administration (VHA) Office of Integrated Veteran Care 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 collaboration of 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 accessible at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000050097/Section-A-Kinesiotherapy-Coverage-and-Billing-Requirements. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. PM&RS Therapy and Rehabilitation Services (PTs, OTs, KTs, PT Assistants, OT Assistants): 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 accessible at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. ***NOTE:*** *This is an internal VA website that is not available to the public.*

c. Claims and Reimbursement for Therapy Services is available in Chapter 7 accessible at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000050165/Section-C-Physical-Therapy-and-Rehabilitation-Services-Reasonable-Charges-and-Billing. ***NOTE:*** *This is an internal VA website that is not available to the public.*