AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Position Statement

Physician-Owned Physical Therapy Services

This position paper was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

Orthopaedic surgeons diagnose and treat patients with musculoskeletal diseases and have worked together with physical therapists for decades to provide high quality, efficient, and convenient care to patients. As a profession, physical therapy (PT) developed through the initiative of doctors specializing in the field of musculoskeletal medicine who sought to enhance the recovery and rehabilitation of their patients through focused training in exercise.[1] This relationship has been beneficial for physical therapists and physicians complementing and overall improving the quality of patient care.

The American Academy of Orthopaedic Surgeons (AAOS) believes that physical therapy is integral to providing high quality care for musculoskeletal disease and injury. Orthopaedic surgeons are best qualified to prescribe clinical and cost-effective use of this service.

Physician Ownership

The Ethics in Patient Referral Act, also known as the Stark Law was passed in 1989 to minimize physician referrals motivated by financial gain. However, the law created an exception which allows a physician to own in-office ancillary services (IOAS).[2] This exception accounts for approximately $8 billion out of the $1.9 trillion spent in annual healthcare costs.[1] Physician owned physical therapy services (POPTS), which account for 3% of Medicare Part B orthopaedic dollars, is one model for the delivery of PT services.[4] Others include free standing PT centers, physical therapists as independent contractors within physician offices, and physical therapists working as employees.

In 2014 the Government Accountability Office (GAO) released their report "Medicare Self-Referral of Physical Therapy Services".[5] Produced at the request of Congress, this report used Medicare Part B claims data to assess trends for "self-referred" (POPTS) and "non-self-referred" Medicare PT services and how use of these services differed among providers. The total number of self-referred PT services showed essentially no increase from 2004 to 2010, whereas non-self-referred services increased by 41%. According to the report, the relationship between provider self-referral status and PT referral patterns was mixed and varied on the basis of referring provider specialty, Medicare beneficiary practice size, and geography, but the GAO "did not find a direct correlation between self-referral and billing per patient."

Additionally, the growth rate in expenditures associated with non-self-referred PT services was also higher than for self-referred services. Self-referring orthopaedic surgeons, on average, referred fewer PT services than non-self-referring orthopaedic surgeons.

The AAOS fully supports efforts to increase the value of musculoskeletal care by both improving quality and lowering costs. Physician ownership allows for appropriate, timely, and scaled delivery of these important services consistent with maximizing their value. As the GAO report demonstrates, orthopaedic surgeons offering the option of PT in the physician office reinforces these fundamental aspects which optimize patient-centered care.

Legislative Activity and the Case for Clinical Integration

The American Physical Therapy Association (APTA) Vision 2020 statement for the future of physical therapy seeks to have its members become doctors of physical therapy with direct access and autonomy over their relationships with patients.[6] Moreover, recently there has been an increased effort to both interpret and augment existing statutory language to prevent physical therapists from working directly for physicians and physician group practices. As we transition from volume to a value-driven healthcare model, care delivery should be evaluated for both cost and quality, of which coordination is a critical component. While there is evidence that increased utilization of in-office services leads to increased total costs (by some measures as much as 30 to 40%), in a value-driven healthcare model, vertical integration of medical services (as opposed to 'dis-integration') will be critical to achieving the necessary cost reductions.[7]

The Case for Integration

Studies available prior to the GAO report offered limited analyses and conflicting results on the potential fiscal impact of POPTS.[7,13] However, none of the studies properly account for the benefits and real savings achieved from vertical integration and clinical coordination. What really is the "right" amount of care? The Dartmouth atlas, as well as numerous other governmental studies, have not reached a uniform opinion as to what is the appropriate amount of musculoskeletal care.[8] Moreover, several studies suggested integrated physical therapy services in the orthopaedic office may actually lead patients to choose more cost-effective nonsurgical options.[9] Lastly, and perhaps most importantly, having coordinated professionals synergistically helping the patient to make a shared decision is most likely to achieve true patient-centered treatment.

The Tangible Benefits of Clinical Integration

Beyond the lower overall cost of utilization, the care coordination team offered by POPTS allows utilization of a common set of resources, technology, and space leading to improvement in overall quality and efficiency. There can be no doubt that patient safety is enhanced in the following ways:

1. Ease of access
2. Ease of scheduling
3. Improved communication
4. Patient compliance and satisfaction [10]
5. Common care pathways
6. Appropriate and accurate orders [11]
7. Ability to modify care
8. Improved physician oversight
9. Improved safety
10. Common electronic health record

The AAOS believes that current legislative efforts to disassemble integrated models of musculoskeletal care ignore many of the tangible benefits of clinical care coordination. Furthermore, these efforts are antithetical to current health care reform efforts to pay for value instead of volume.

Summary

The AAOS believes that patients should have access to quality, comprehensive, and coordinated care. Through improved flow and continuity, integration has the potential not only to deliver superior health outcomes, but also decrease total costs. Continued access to a professional team of musculoskeletal providers, working together, will provide this high quality efficient care. Moreover, integration facilitates a shared decision process that provides the greatest chance of achieving the "right" amount and type of care for each individual patient.[12] Based on the GAO report, fragmenting this coordinated team approach will most likely lead to increased costs and can also impact patient safety. Orthopaedic surgeons who integrate and employ physical therapists are promoting cost-effective care coordination to their patients.

The AAOS is committed to working with a broad range of public and private entities to improve the value of healthcare. Physician-owned physical therapy services are central to the provision of integrated, high quality musculoskeletal care.

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Position Statement 1166

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