

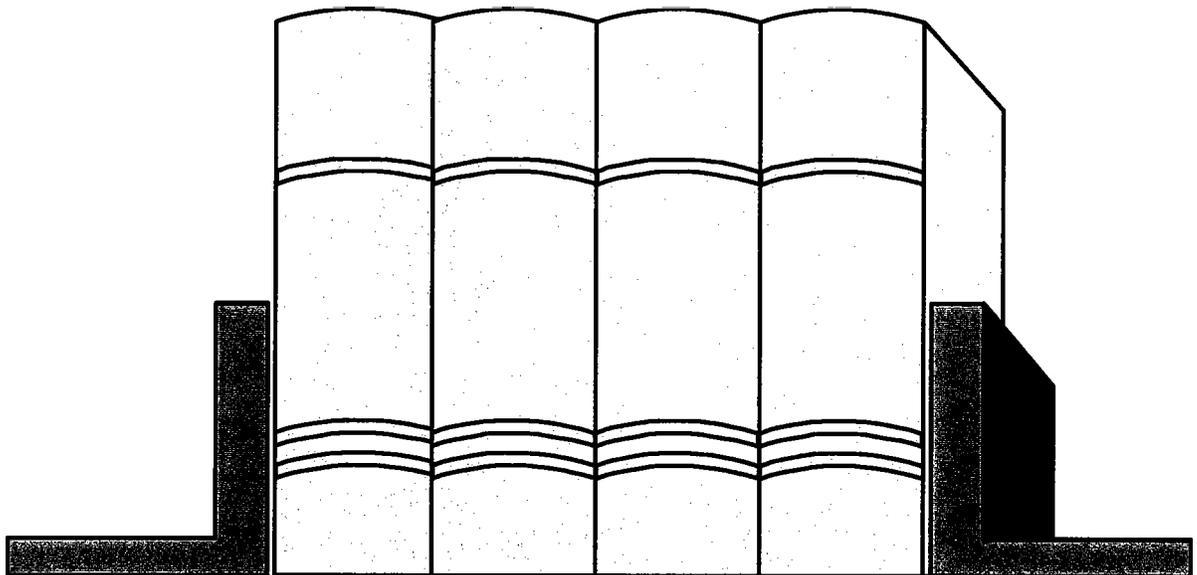
# AAOS

American Association of Orthopaedic Surgeons

## *Resource Guide On*

# **Direct Access to Physical Therapy**

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American Association of Orthopaedic Surgeons

American Association of  
Orthopaedic Surgeons

## DEPARTMENT OF SOCIOECONOMIC AND STATE SOCIETY AFFAIRS

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## MEMORANDUM

**To: Readers of the AAOS Resource Guide on Scope of Practice/Physical Therapy**

**From: American Association of Orthopaedic Surgeons**

**Re: AAOS Resource Guide on Scope of Practice/Physical Therapy**

The AAOS's Department of Socioeconomic & State Society Affairs has prepared this Resource Guide on Scope of Practice issues involving direct access to care for physical therapists.

This information was collected to provide reference and background information to state orthopaedic societies. **This information is presented for educational purposes only.**

For any additional information please feel free to contact Jay Fisher, Legislative Analyst at 847-384-4336.

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# **TAB ONE**

## **STATE STATUTES AND LEGISLATION**

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# **An Analysis of the 39 State Statutes APTA Claims Permit Treatment by Physical Therapists Without Referral as of 6/2004**

## **Introduction**

One of the main legislative goals of the physical therapy industry is to statutorily allow patients direct access to treatment by a physical therapist without first having to visit a physician and obtaining a referral. The American Physical Therapy Association (APTA) defines direct access as "the right of an individual to obtain treatment from a licensed physical therapist where and when he or she may choose."

APTA describes physical therapy treatments to include, "therapeutic exercises, functional training, development and use of assistive devices and equipment, manual techniques (including mobilization and manipulation), airway clearance techniques, and electrical, physical and mechanical modalities."

These treatments are used to treat orthopaedic conditions (such as neck pain and osteoporosis), joint and soft tissue injuries (such as fractures and dislocations), neurological conditions (such as stroke, traumatic brain injury and Parkinson's disease), connective tissue conditions (such as ulcers, burns and wounds), arthritic conditions, cardiopulmonary and circulatory conditions (such as congestive heart failure and emphysema) and workplace and sports injuries.

## **APTA Claims on Direct Access**

APTA asserts that thirty-nine states currently allow physical therapists direct access to patients without a referral from a physician or other licensed health practitioner.

These states are: Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

Our analysis of the statutory language shows that only eighteen of the thirty-nine states claimed by APTA have clear statutory language allowing direct access to treatment. The sixteen states with clear statutory mandates allowing direct access are: Arkansas, Delaware, Florida, Iowa, Louisiana, Maine, Minnesota, Montana, New Hampshire, New Jersey, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Virginia, Wisconsin (by statute and an administrative rule) and Wyoming.

Contrary to the APTA claims the statutes in twenty-one of the thirty-nine states do not specifically allow for direct access. Four states have clear language allowing access only upon referral of a physician. The four states with language requiring a referral are: Illinois, Kentucky, Tennessee, and Texas. The other seventeen states have ambiguous language or are silent on the topic.

The remaining states with ambiguous or no language on this question are: Alaska, Arizona, California, Colorado, Idaho, Maryland, Massachusetts, Nebraska, Nevada, New Mexico (referral except for "acute care"), North Carolina, North Dakota, South Dakota, Utah, Vermont, Washington and West Virginia.

In the absence of an administrative or judicial ruling that declares otherwise, the claim that the statutes in these states allow patients direct access to physical therapists for treatment is incorrect.

## **State-by-State Analysis**

### **Alaska** Title 8, Chapter 84

#### *Statutory Definitions*

The Alaska statute defines the scope of practice of a Physical Therapist (PT) by stating that "this chapter does not authorize a person to practice medicine, osteopathy, chiropractic, or other method of healing, but only to practice physical therapy."

The definition of physical therapy in Alaska is "examination, treatment and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, bodily malfunction, pain from injury, disease and other bodily or mental conditions and includes the administration, interpretation and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation and modification of treatment and instruction including the use of physical measures, activities and devices for preventive and therapeutic purposes; the provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction and pain; 'physical therapy' does not include the use of roentgen rays and radioactive materials for diagnosis and therapeutic purposes, the use of electricity for surgical purposes, and the diagnosis of disease."

The statute includes as grounds for discipline when a PT "has failed to refer a patient to another qualified professional when the patient's condition is beyond the training or ability of the person."

#### *Discussion*

While a PT cannot diagnose disease or practice medicine under the statute, it is silent on whether PTs can treat physical injuries without a referral from a physician.

These three statutory provisions are fairly uniform throughout the states analyzed in this paper. In most states that do not have specific language allowing or restricting direct access, the right to access would have to be derived from interpreting this ambiguous language.

## **Arizona** Title 32, Chapter 19

### *Statutory Definition*

The statute states that physical therapy means "examining, evaluating and testing" in "order to determine a diagnosis, a prognosis and a plan of therapeutic intervention." Additionally, the statute requires a physical therapist to refer a client to an appropriate health care practitioners if the physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice of physical therapy.

### *Discussion*

The statute is silent on the question of direct access to physical therapy treatment.

## **Arkansas** Title 17, Chapter 93

### *Statutory Definition*

Statute defines physical therapy to include "examining and evaluating patients . . . in order to determine a physical therapy diagnosis, prognosis, and planned therapeutic intervention." Later, the definition states, "[T]he therapeutic intervention of bronchopulmonary hygiene, and debridement and wound care requires a physician referral prior to initiation of treatment."

### *Discussion*

It is clear from the statute that the therapeutic intervention of bronchopulmonary hygiene, and debridement and wound care requires a prior referral before treatment. It is unclear whether the other allowed therapeutic interventions require a physician referral.

## **California** Business & Professions Code Div.2, Chapter 5.7 Sections 2620-2621

### *Statutory Definition*

The statutory definition of physical therapy in Section 2620 is "the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services," but does not include the diagnosis of disease.

In a later section, the code states that a "physical therapist may, upon specified authorization of a physician and surgeon, perform tissue penetration for the purpose of evaluating neuromuscular

performance as a part of the practice of physical therapy and provided the physical therapist does not develop or make diagnostic or prognostic interpretations of the data obtained."

Section 2621 goes on to say "nothing in this chapter shall be construed as authorizing a physical therapist to practice medicine, surgery, or any other form of healing except as authorized by Section 2620."

### *Discussion*

The California statute differs subtly, but in an important way, from the Arkansas statute discussed above. In California, the language discussing a physician's authorization (note that it does not say referral) is in its own section. The purpose of the language is not to carve out a subset of a therapist's scope requiring a referral, but to add to it. A physical therapist can use his judgment when treating a patient referred to him, but if he wants to perform tissue penetration he must get a specific (not general) referral from a physician authorizing that *specific* procedure.

Reading the other statutory sections they do not directly address the question of whether a patient needs a physician's referral before seeking treatment from a PT.

## **Colorado** Title 12, Article 41

### *Statutory Definition*

Statutory definition of physical therapy is "examination, treatment, or instruction of human beings to detect, assess, prevent, correct, alleviate, or limit physical disability, movement dysfunction, bodily malfunction, or pain from injury, disease, and other bodily conditions." Additionally, this includes the "administration, evaluation, and interpretation of tests" and the "planning, administration, evaluation, and modification of treatment."

Disciplinary action can be taken if the PT fails to "refer a patient to the appropriate licensed health care practitioner when the services required by the patient are beyond the level of competence of the physical therapist or beyond the scope of physical therapy practice."

### *Discussion*

Again the statute is silent on the question of whether a patient can receive the authorized treatment from a physical therapist without a referral. The web site of the Colorado Physical Therapy Licensure Program, though, claims that direct access is allowed in Colorado even if the statute and regulations are silent on the issue.

## **Delaware** Title 24, Chapter 26

### *Statutory Definition*

The Delaware statute addresses the right to treatment without a referral by stating: "[A] licensed physical therapist may enter a case for the purpose of consultation, evaluation or treatment of an individual as it relates to the individual's need for physical therapy services, with or without a referral by a licensed medical or osteopathic physician; provided, however, that a physical therapist shall refer the individual to another health practitioner if symptoms are present for which treatment is outside the scope of the physical therapist's knowledge. A physical therapist may treat an individual without a referral up to 30 days after which time a physician must be consulted."

### *Discussion*

The statute clearly states that a PT can treat a patient without a referral for up to thirty days.

## **Florida** Title XXXII, Chapter 486

### *Statutory Definition*

Florida, like Delaware, addresses this issue with direct language. The statute states that "a physical therapist may implement a plan of treatment for a patient. The physical therapist shall refer the patient to or consult with a health care practitioner . . . , if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record, the physical therapist shall obtain a practitioner of record who will review and sign the plan."

### *Discussion*

Thus, a PT may treat a patient for twenty-one days before the patient must see a practitioner.

## **Idaho** Title 54-2203

### *Statutory Definition*

The statutory definition of the practice of physical therapy is similar to Colorado's. The statute goes on to give power to the Board to discipline a PT who "practices physical therapy and fails to refer to a licensed medical physician, osteopathic physician, podiatrist, or dentist, any patient whose medical condition should have, at the time of evaluation or treatment, been determined to be beyond the scope of practice of a physical therapist." Another sections states that, "one who practices physical therapy may refer patients to a licensed medical physician, osteopathic physician, podiatrist, dentist or chiropractic physician."

### *Discussion*

Again, the statute is silent on the question of whether a patient can receive the authorized treatment from physical therapists without a referral, it states that PTs may refer patients to other physicians, but does not mention how the patients must originally come to the PT.

## **Illinois 225 ILCS 90**

### *Statutory Definition*

The Illinois statute states that physical therapy is the "evaluation or treatment of a person" by a list of means. It goes on to note that the practice includes both the "interpretation of referrals from physicians, dentists and podiatrists" and the "establishment, and modification of physical therapy treatment programs."

The statute goes on to require a physical therapist to "refer to a licensed physician, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the physical therapist."

The statute defines "referral" as "the following of guidance or direction to the physical therapist given by the physician, dentist, or podiatrist who shall maintain supervision of the patient."

Another definition included is for "Documented current and relevant diagnosis" which means "a diagnosis, substantiated by signature or oral verification of a physician, dentist, or podiatrist, that a patient's condition is such that it may be treated by physical therapy as defined in this Act, which diagnosis shall remain in effect until changed by the physician, dentist or podiatrist."

This term is used in the provision that lists reasons for discipline. A PT may be disciplined if they "treated ailments of human beings as a licensed physical therapist independent of a documented referral or a documented current and relevant diagnosis from a physician, dentist, or podiatrist, or having failed to notify the physician, dentist or podiatrist who established a documented current and relevant diagnosis that the patient is receiving physical therapy pursuant to that diagnosis."

### *Discussion*

Reading this last requirement with the definitions of referral and documented current and relevant diagnosis it seems clear that a PT may only treat a patient upon referral from a physician, dentist or podiatrist.

## **Iowa** Chapter 148A.1

### *Statutory Definition*

The Iowa statute states that "physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital's medical staff."

### *Discussion*

Therefore, outside of a hospital, no referral is needed for treatment and there is no maximum length of treatment identified. For physical therapy performed in a hospital context it is up to the hospital to decide if a prior medical examination is required before physical therapy treatment begins.

## **Kentucky** Title 26, Chapter 327

### *Statutory Definition*

The statutory definition states that physical therapy includes "planning, organizing and directing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury, encompassing preventive measures, screening, tests in aid of diagnosis by a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry and evaluation and invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular and cardiopulmonary function, as it relates to physical therapy."

The section goes on to say that physical therapy "also includes physical therapy treatment performed upon referral by a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry including, but not limited to, exercises for increasing or restoring strength, endurance, coordination and range of motion, stimuli to facilitate motor activity and learning, instruction in activities of daily living and the use of assistive devices and the application of physical agents to relieve pain or alter physiological status."

The definition for referral is a "procedure by which a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry designates the initiation of physical therapy treatment by a licensed physical therapist."

### *Discussion*

The statute states that physical therapy involves tests "in aid of diagnosis" by a licensed doctor and treatment upon the referral of a licensed doctor of medicine. Types of permissible treatment upon a referral are specifically listed and are widened by the inclusion of the phrase "but not limited to."

Therefore PTs may perform treatment on patients only upon referral from a licensed doctor of medicine, osteopathy, etc.

## **Louisiana** Revised Statutes, Title 37, Section 2410

### *Statutory Definition*

Under Louisiana law a “physical therapist licensed under this Chapter shall not perform physical therapy services without a prescription or referral from a person licensed to practice medicine, . . . . However, a physical therapist licensed under this Chapter may perform physical therapy services without a prescription or referral under the following circumstances:

(5)(a) To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety days. The physical therapist shall provide the health care provider who rendered such diagnosis with a plan of care for physical therapy services within the first fifteen days of physical therapy intervention.

(b) Nothing in this Chapter shall be construed to create liability of any kind for the health care provider rendering the diagnosis pursuant to this Subsection for a condition, illness, or injury that manifested itself after such diagnosis or for any alleged damages as a result of physical therapy services performed without a prescription or referral from a person licensed to practice medicine, surgery, dentistry, podiatry, or chiropractic.”

### *Discussion*

Clearly a PT can treat without a referral if they notify the physician and the patient has been diagnosed within the previous ninety days. This is the only bill that attempts to provide liability protection for the patient’s physician.

## **Maine** Title 32, Chapter 45-A

### *Statutory Definition*

The Maine statute in its licensing section lays out what acts are permitted by a physical therapist without a referral by a physician. The PT may not make a medical diagnosis and "shall refer to a licensed doctor of medicine, osteopathy, podiatry, dentistry or chiropractic a patient whose physical condition, either at the initial evaluation or during subsequent treatment, the physical therapist or physical therapist assistant determines to be beyond the scope of the practice of the physical therapist or physical therapist assistant."

The statute goes on to say "[n]othing in this chapter may be construed as authorizing a physical therapist or physical therapist assistant, licensed or not licensed, to practice medicine, osteopathy, dentistry, chiropractic or any other form of healing, except that physical therapists may utilize

manipulative techniques if practiced within the scope of their profession. Physical therapists may not apply manipulative thrust to the vertebrae of the spine except upon consultation with, and referral by, a duly licensed doctor of medicine, surgery, chiropractic or osteopathy. A licensed physical therapist or physical therapist assistant may not administer drugs except upon the referral of a duly licensed doctor of medicine, surgery, osteopathy, podiatry or dentistry, and may not use roentgen rays or radium or use electricity for surgical purposes."

Additionally, if no improvement is made by the patient within thirty days the patient must be referred to a doctor.

Lastly, for treatment lasting longer than 120 days the PT shall consult with or refer the patient to a doctor.

### *Discussion*

The statute states that for at least thirty days there is a right to treat patients without a referral except for the treatment options that require a referral by a licensed doctor.

The statute, though, raises some interesting questions. If the PT may not make a medical diagnosis how can they decide what to treat? A PT may make an evaluation, but not a diagnosis. What is real world difference in these words?

## **Maryland** Title 13, Section 13

### *Statutory Definition*

The Maryland statute defines physical therapy to include:

- "(i) Performing an evaluation of the physical therapy needs of individuals;
- (ii) Performing and interpreting tests and measurements of neuromuscular and musculoskeletal functions to aid treatment;
- (iii) Planning treatment programs that are based on test findings; and
- (iv) . . . administering treatment . . . ."

A PT may be disciplined for, among other things, "practicing physical therapy inconsistent with any written or oral order of:

- (i) A physician authorized to practice medicine in any state."

Administrative Regulation 10.38.03.02 lists standards for PTs which include "the physical therapist may decline to carry out evaluation or treatment that has been ordered if, in his judgment, it is contraindicated or unjustified and shall so notify the referring practitioner."

### *Discussion*

The statute is unclear as to if or when a referral is needed. It allows PTs to do tests, plan treatment programs, and administer such programs. It does not state how the patient gets to the office. A PT

may be disciplined for *violating* a referral from a physician, but it does not state that a PT can be disciplined for practicing *without* a referral. The Regulation, though, makes it appear that there *always* will be a referring physician.

## **Massachusetts** Part I, Title XVI, Chapter 112, Section 23

### *Statutory Definition*

The Massachusetts law defines physical therapy as a "health profession that utilizes the application of scientific principles for the identification, prevention, remediation and rehabilitation of acute or prolonged physical dysfunction thereby promoting optimal health and function. Physical therapy practice is evaluation, treatment and instruction related to neuromuscular, musculoskeletal, cardiovascular and respiratory functions."

The text goes on to say that "[s]uch evaluation shall include but is not limited to performance and interpretation of tests as an aid to the diagnosis or planning of treatment programs."

The statute also states that a physical therapist may not practice medicine.

### *Discussion*

While this language in isolation again is unclear on the permissibility of direct access, a look at past amendments may provide some clarity to the question. LEXIS-NEXIS states that in 1975 the definition of a physical therapist was amended by the legislature from a person who practices physical therapy under the supervision of a licensed physician to a person who practices upon the referral of a registered physician.

While LEXIS-NEXIS does not note when the requirement of a referral was deleted from the section, it is not currently in the statute. This change by the legislature implies that a referral is not needed prior to treatment.

This conclusion is bolstered by a regulation, 259 CMR 5.05 which institutes a code of ethics and states: "the Code of Ethics, Guide for Professional Conduct and Standards of Physical Therapy Services and Physical Therapy Practitioners of the APTA, in their most recently updated formats, are adopted as the ethical standards of practice for persons holding a license to practice physical therapy.

(a) As provided in the Code of Ethics, when a referral relationship exists, the physical therapist will provide ongoing communication with the licensed referring practitioner regarding changes in plans of care, treatment programs, and termination of services.

(b) When there is no practitioner referral, the physical therapist must refer to a licensed practitioner of medicine, dentistry, or podiatry if symptoms are present of which physical therapy is contraindicated or which symptoms are indicative of conditions for which treatment is outside the scope of practice of the physical therapist."

## **Minnesota** Chapter 148.65

### *Statutory Definition*

Under the disciplinary section of the Minnesota statute, a PT can be disciplined for "treating human ailments by physical therapy after an initial 30-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state in the practice of medicine or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by board of physical therapy rule."

The next sentence adds "treating human ailments, without referral, by physical therapy treatment without first having practiced one year under a physician's orders as verified by the board's records" as improper behavior.

The next disciplinary category is "failing to consult with the patient's health care provider who prescribed the physical therapy treatment if the treatment is altered by the physical therapist from the original written order. The provision does not include written orders to 'evaluate and treat.'" Also included is "practicing physical therapy and failing to refer to a licensed health care professional a patient whose medical condition at the time of evaluation has been determined by the physical therapist to be beyond the scope of practice of a physical therapy."

Lastly, the statute states that a PT may not "treat human ailments by physical therapy after an initial 30-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state to the practice of medicine, the practice of chiropractic, the practice of dentistry, the practice of podiatry, or the practice of advanced practice nursing, when orders or referrals are made in collaboration with a physician, chiropractor, podiatrist, or dentist, and whose license is in good standing; or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by board of physical therapy rule."

The Administrative Rule in Chapter 5601 states that "a physical therapist who has had more than one year of clinical experience may initiate treatment of a patient for a condition not previously diagnosed for up to 30 calendar days from the date of initial treatment once within a four-month period without referring to a licensed health care professional."

### *Discussion*

The best analysis of this long-winded legalese is that a PT can treat a patient for thirty days without a prior referral if the PT has practiced for one year under a physician, but it is not all clear. This language is made somewhat clearer by the Administrative Rule which says that treatment may be initiated for an undiagnosed condition.

## **Montana** Title 37, Chapter 11

### *Statutory Definition*

The Montana statute delineates proper physical therapy technique as "(1) Physical therapy evaluation includes the administration, interpretation and evaluation of tests and measurements of bodily structures and functions; the development of a plan of treatment; consultative, educational and other advisory services; and instruction and supervision of supportive personnel. (2) treatment employs, for therapeutic effects, physical measures, activities and devices, for preventive and therapeutic purposes, exercises, rehabilitative procedures, massage, mobilization, and physical agents including but not limited to mechanical devices, heat cold, air, light, water, electricity and sound. (3) the evaluation and treatment procedures listed in subsections (1) and (2) may be performed by a licensed physical therapist without referral."

### *Discussion*

Section three of the statute clearly states that a PT may have direct access to patients for treatment without a referral.

## **Nebraska** Chapter 71-2800

### *Statutory Definition*

The Nebraska physical therapy statute is completely silent on the issue of direct access. The physical therapy section of the statute book is only four sections long. The definition of physical therapy is "the treatment of any bodily condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, massage, and active or passive exercise. It shall not include the use of roentgen rays and radium for diagnostic and therapeutic purposes, including cauterization."

### *Discussion*

The statute is silent on the issue of direct access to treatment.

## **Nevada** Title 54, Chapter 640

### *Statutory Definition*

The statutory definition of physical therapy is "the specialty in the field of health which is concerned with prevention of disability and physical rehabilitation of persons having congenital or acquired disabilities." The practice of physical therapy includes "a) [t]he performing and interpreting of tests and measurements as an aid to evaluation or treatment; (b) The planning of initial and subsequent programs of treatment on the basis of the results of tests; and (c) The administering of treatment

through the use of therapeutic exercise and massage, the mobilization of joints by the use of therapeutic exercise without chiropractic adjustment, mechanical devices, and therapeutic agents which employ the properties of air, water, electricity, sound and radiant energy.

2. Does not include: (a) The diagnosis of physical disabilities;"

### *Discussion*

Again, we find a statute that is silent on the topic of direct access to treatment without a prior referral from a physician. The PT may evaluate disabilities, but may not diagnose disabilities.

## **New Hampshire** Title 30, Chapter 328A

### *Statutory Definition*

New Hampshire law sets up two classes of PTs: one class who needs a referral and one class who can have direct access. A Physical Therapist II may "evaluate and develop a working diagnosis for treatment by physical therapy without a referral, but shall obtain consultation with a person licensed to practice medicine . . . in order to continue treatment beyond 75 consecutive days." The consultation does not need to be in writing and if there is no improvement within 30 days the patient must be referred to a physician. A Physical Therapist I can only practice upon the referral of a licensed doctor, podiatrist, etc.

To be a Physical Therapist II requires at least 2 years experience as a licensed physical therapist, completion of continuing education as established by the board, and references from 2 physicians with whom the therapist has had a working relationship.

### *Discussion*

The law makes specific provision for Physical Therapists II to practice for seventy-five days without a referral from a physician.

## **New Jersey** P.L. 2003, c. 18

### *Statutory Definition*

The PT Board shall pass a Rule "setting forth the conditions under which a physical therapist is required to refer an individual being treated by a physical therapist to or consult with a practitioner licensed to practice dentistry, podiatry or medicine and surgery in this State, or other appropriate licensed health care professional. Pending adoption of the standards: (a) a physical therapist shall refer any individual who has failed to demonstrate reasonable progress within 30 days of the date of initial treatment to a licensed health care professional; and (b) a physical therapist, not more than 30 days from the date of initial treatment of functional limitation or pain, shall consult with the individual's licensed health care professional of record as to the appropriateness of the treatment, or,

in the event that there is no identified licensed health care professional of record, recommend that the individual consult with a licensed health care professional of the individual's choice.”

### *Discussion*

The PT can treat without a referral for thirty days before referring or consulting with a health care professional.

## **New Mexico** Chapter 61-12D

### *Statutory Definition*

The New Mexico statutory definition of physical therapy includes, "examining and evaluating patients . . . in order to determine a physical therapy diagnosis, prognosis and planned therapeutic intervention."

The statute goes on in a different subsection to note, "[a] physical therapist shall not accept a patient for treatment without an existing medical diagnosis for the specific medical or physical problem made by a licensed primary care provider, except for those children participating in special education programs in accordance with [Section 22-13-5](#) NMSA 1978 and for acute care within the scope of practice of physical therapy."

The dictionary definition of acute is:

**Acute:** describes a condition or illness that begins suddenly and is usually short-lasting

**Acute:** Of short duration, rapid and abbreviated in onset, in reference to a disease. “Acute” is a measure of the time scale of a disease and is in contrast to “subacute” and “chronic.”

### *Discussion*

The statute allows direct access for treatment only for acute care, but does not define what acute care is in the statute. Therefore, direct access not allowed except for only one type of care, but it is unclear what it entails and for how long treatment may be performed.

## **North Carolina** Chapter 90-270.24

### *Statutory Definition*

The statutory definition in North Carolina states:

"Physical therapy' means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment

of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. . . . Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina, or medical diagnosis of disease."

Discipline may be imposed if a PT practices "physical therapy and fail[s] to refer to a licensed medical doctor or dentist any patient whose medical condition should have, at the time of evaluation or treatment, been determined to be beyond the scope of practice of a physical therapist."

#### *Discussion*

The North Carolina statute is silent on the issue of whether a patient needs a prior referral from a physician before treatment by a PT, though it does limit the use of certain techniques unless prescribed by a physician.

## **North Dakota** Chapter 43-26

#### *Statutory Definition*

The statutory definition in North Dakota states the "practice of physical therapy means the practice of the health specialty, and encompasses physical therapy evaluation, treatment planning, instruction, and consultative services, including:

- a. Performing and interpreting tests and measurements as an aid to physical therapy treatment.
- b. Planning initial and subsequent treatment programs, on the basis of test findings.
- c. Administering treatment by therapeutic exercise, neurodevelopmental procedures, therapeutic massage, mechanical devices, and therapeutic agents which employ the physical, chemical, and other properties of air, water, heat, cold, electricity, sound, and radiant energy for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability."

Additionally, the Board may discipline a PT if "at the time of evaluation" the PT does not refer a patient to a licensed healthcare professional when his condition is beyond the scope of practice of a PT.

#### *Discussion*

Again, the statute is silent on the issue of whether a patient can be treated by a PT without first obtaining a referral.

## **Ohio** Title 47, Section 4755.48 and Section 4755.481

### *Statutory Definition*

The statute states that “No person shall practice physical therapy other than on the prescription of, or the referral of a patient by, a person who is licensed in this or another state to practice medicine and surgery . . . , within the scope of such practices, and whose license is in good standing, unless either of the following conditions is met:

- (1) The person holds a master's or doctorate degree from a professional physical therapy program that is accredited by a national accreditation agency recognized by the United States department of education and by the Ohio occupational therapy, physical therapy, and athletic trainers board.
- (2) On or before December 31, 2003, the person has completed at least two years of practical experience as a licensed physical therapist. “

The statute goes on to say “If a physical therapist evaluates and treats a patient without the prescription of, or the referral of the patient by, a person who is licensed to practice medicine and surgery . . . , all of the following apply:

- (1) The physical therapist shall, upon consent of the patient, inform the patient's physician . . . of the evaluation not later than five business days after the evaluation is made.
  - (2) If the physical therapist determines, based on reasonable evidence, that no substantial progress has been made with respect to that patient during the thirty-day period immediately following the date of the patient's initial visit with the physical therapist, the physical therapist shall consult with or refer the patient to a licensed physician . . . , unless either of the following applies:
    - (a) The evaluation, treatment, or services are being provided for fitness, wellness, or prevention purposes.
    - (b) The patient previously was diagnosed with chronic, neuromuscular, or developmental conditions and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions.
  - (4) If, at any time, the physical therapist has reason to believe that the patient has symptoms or conditions that require treatment or services beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a licensed health care practitioner acting within the practitioner's scope of practice.
- (B) Nothing in sections 4755.40 to 4755.56 . . . shall be construed to require reimbursement under any health insuring corporation policy, contract, or agreement, any sickness and accident insurance policy, the medical assistance program as defined in section 5111.01 of the Revised Code, or the health partnership program or qualified health plans established pursuant to sections 4121.44 to 4121.443 of the Revised Code, for any physical therapy service rendered without the prescription of, or the referral of the patient by, a licensed physician . . . .”

## *Discussion*

In Ohio PTs can treat without a referral if they have a Masters or PhD in PT or if they had been in practice for two years as of December 31, 2003. The PT must inform the physician of his or her evaluation within five days. If the PT believes no progress has been made within 30 days he or she must consult with or refer to a physician unless the patient has already been diagnosed with “chronic, neuromuscular, or developmental conditions.”

## **Oregon** Chapter 688

### *Statutory Definition*

The code states that the, "Board shall establish by rule education requirements that a physical therapist must meet before administering physical therapy to a person without prior referral as authorized by ORS 688.132."

For those PTs who do not qualify for this right, the code, in ORS 688.130, states that no therapy may be done except where there has been evaluation of the dysfunction by the PT and a referral from a physician, podiatrist etc. The next section, ORS 688.132, states that if a PT administers therapy as authorized under the section requiring evaluation they must "immediately" refer the person to a doctor if symptoms are present requiring treatment beyond the scope of practice or the PT continues therapy and thirty days have passed since the initial treatment has been administered. That is unless the person is a special education child, student athlete or in a long-term care facility then no referral is needed.

The rules lay out what education is required for direct access in 848-030-0000. The PT (1) Hold a CPR certificate, Level C, issued by the American Heart Association, or equivalent, which shall be kept current.

(2) Complete a course which provides at least 18 hours of instruction designed to enable the physical therapist to identify signs and symptoms of systemic disease, particularly those that can mimic neurological or musculoskeletal disorders, and to recognize conditions which require timely referral to a medical doctor

(3) Within the three years immediately following the completion of the requirements in section (2) of this rule, a physical therapist who is administering physical therapy without prior referral shall complete at least an additional 32 hours of continuing education. Thereafter, such physical therapist must complete at least 50 hours of continuing education every three years.

The rule goes on to say that the PT allowed direct access must immediately refer the patient to a doctor if symptoms are present requiring treatment beyond the scope of practice or the PT continues therapy and thirty days have passed since the initial treatment has been administered unless the person is a special education child, student athlete or in a long-term care facility.

### *Discussion*

The statute seems to say that if a PT meets the educational requirements they may treat patients without a prior referral, but it states that that authorization is in 688.132 which deals with the

requirement of subsequent referrals not prior referrals. The section that deals with prior referrals is 688.130. For those PTs who do not meet the educational requirement a referral is needed before treatment may commence.

## **Pennsylvania** Act 6 of 2002

### *Statutory Definition*

Pennsylvania law provides that PTs who meet the standards may apply to the board for a certificate of authorization to practice physical therapy without the required referral. A certificate of authorization to practice physical therapy without a referral shall not authorize a physical therapist either to treat a condition in any person which is a nonneurologic, nonmuscular or nonskeletal condition or to treat a person who has an acute cardiac or acute pulmonary condition unless the physical therapist has consulted with the person's licensed physician, dentist or podiatrist regarding the person's condition and the physical therapy treatment plan or has referred the person to a licensed physician, dentist or podiatrist for diagnosis and referral.

The PT must have passed an “examination included testing on the appropriate evaluative procedures to treat a person without a referral” or “successfully completed a course approved by the board on the appropriate evaluative procedures to treat a person without a referral.”

Additionally the PT must have practiced for two consecutive years before applying for a Certificate to treat without a referral. A physical therapist practicing physical therapy “shall refer patients to a licensed physician or other appropriate health care practitioner in any of the following cases:

(1) Cases where symptoms are present for which physical therapy is a contraindication.

(2) Cases for which treatment is outside the scope of practice of physical therapy.

(3) Cases for which treatment is beyond the education, expertise or experience of the physical therapist.

(e) A physical therapist may treat a person without a referral as provided for in subsection (b) for up to 30 days from the date of the first treatment. A physical therapist shall not treat a person beyond 30 days from the date of the first treatment unless he or she has obtained a referral from a licensed physician, dentist or podiatrist. The date of the first treatment for purposes of this subsection is the date the person is treated by any physical therapist treating without a referral.”

### *Discussion*

The Pennsylvania law clearly allows physical therapists to treat patients without a referral if they obtain a certificate of authorization. They may only treat for thirty days.

## **Rhode Island** Chapter 5-40

### *Statutory Definition*

The Rhode Island statute states that PTs with more than one-year clinical experience may treat patients without a referral from a doctor of medicine. When a patient is treated without a referral, the patient must be given in writing the scope of practice of physical therapy and sign their consent thereto. Also, the patient must be referred to a practitioner within ninety days after commencement of treatment.

### *Discussion*

Physical Therapists with under one year of practice may only treat upon a referral, but after their first year they may have direct access for ninety days if the patient gives their consent.

## **South Carolina** Title 40, Chapter 45

### *Statutory Definition*

South Carolina law states that a PT may be disciplined if they "in the absence of a referral from a licensed medical doctor or dentist, provide physical therapy services beyond thirty days after the initial evaluation and/or treatment date without the referral of the patient to a licensed medical doctor or dentist."

### *Discussion*

Reading this section a PT may treat ailments within their scope of practice for thirty days before a referral from a doctor is needed.

## **South Dakota** Chapter 36-10

### *Statutory Definition*

The definition of the practice of physical therapy in South Dakota includes the "examination and evaluation" of patients in order to determine a "diagnosis, prognosis and therapeutic intervention."

Additionally, there is a section entitled "Professional supervision required for treatment by physical therapist," but this section was repealed in 1986 which is also the year APTA claims direct access was allowed in South Dakota.

Lastly, the statute outlines what a PT Assistant may not do which includes interpreting referrals, initial evaluations and development of a plan of care based upon the initial evaluation.

## *Discussion*

The statutory language on the books now is unclear as to if and when referrals are needed for physical therapy treatment.

## **Tennessee** Title 63, Chapter 13

### *Statutory Definition*

Tennessee provides another example of a state specifically mentioning access without referral, but having references that muddy the picture.

The code states that "the scope of practice of physical therapy shall be under the written or oral referral of a licensed doctor of medicine . . . with exceptions as stated in § [63-13-301](#)."

Now, 63-13-301 simply states "(a) A physical therapist licensed under this chapter is fully authorized to practice physical therapy as defined in this chapter. (b) No person shall practice, or in any manner claim to be engaging in the practice of physical therapy or designate as being a physical therapist unless duly licensed as a physical therapist in accordance with this chapter."

That language doesn't mention referrals, but the next two sections do. Section 63-13-302 states that "[a] physical therapist shall refer persons under the physical therapist's care to appropriate health care practitioners, after consultation with the referring practitioner, if the physical therapist has reasonable cause to believe symptoms or conditions are present which require services beyond the scope of practice or when physical therapy treatment is contraindicated."

Section 63-13-303 seems like the most logical section for reference to exceptions and I believe that the reference to Section 301 is a drafting or technical error. Section 63-13-303 states that all therapy shall be under the referral of a physician except: "(1) The initial evaluation which may be conducted without such referral; 2) A licensed physical therapist may treat a patient for an injury or condition that was the subject of a prior referral if all of the following conditions are met." Those conditions are consultation with the referring physician within four days, treatment lasts ten sessions or fifteen days whichever is less, and treatment must commence within one year of the referral. Lastly, the section allows emergency care without a referral.

This understanding is reinforced by looking at the administrative rule which states that "the scope of practice of physical therapy shall be under the written or oral referral of a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy, with the following exceptions, as provided in T.C.A. § 63-13-303.

1. The initial evaluation which may be conducted without such referral;
2. A licensed physical therapist may treat a patient for an injury or condition that was the subject of a prior referral if all of the following conditions are met." The conditions are the same as are outlined in the statute. The rule goes on to say that "no physical therapist may provide treatment pursuant to part two (2) of this subparagraph without having been licensed to practice physical therapy for at least one (1) year and without satisfying other requirements set by the Committee."

### *Discussion*

In Tennessee physical therapy *treatment* must be performed after a referral from a practitioner. Only *evaluation* can be performed without the prior referral of a licensed practitioner. Treatment based on a prior referral may only be done by PTs having one year in practice.

## **Texas** Vernon civil statutes Article 4512e

### *Statutory Definition*

The Texas statute is very similar to the Tennessee statute. It states that a physical therapy license may be denied if a PT has "provided physical therapy to a person, except as provided by Subdivision (2) of this subsection, without the referral from a physician licensed to practice medicine . . . ." Subsection (2) states, "[a] licensed physical therapist may treat a patient for an injury or condition that was the subject of a prior referral if all of the following conditions are met." Those conditions are: notification of the physician within five days, twenty visits or thirty days whichever is earlier, and commencement of treatment within one year from the referral.

### *Discussion*

Unlike the Tennessee statute, the Texas statute does not allow treatment or an evaluation without a prior referral.

## **Utah** Title 58, Chapter 24a

### *Statutory Definition*

The Utah statute is completely silent on the question of direct access to treatment. Physical therapy is defined as "treatment of a human being to assess, prevent, correct, alleviate, and limit physical disability." The definition goes on to include, "development of a physical therapy plan and the implementation of and modification of the treatment plan."

The statute goes on to list all the tests and agents that the PT may use in their treatment. Another section states that "physical therapists may perform examinations and evaluations to aid in developing a treatment goal upon which a physical therapy plan is based."

Lastly, a PT may not perform surgery or diagnosis of disease.

### *Discussion*

There is nothing in the statute that dictates either requiring or not requiring a referral for treatment.

## **Vermont** Title 26, Chapter 38

### *Statutory Definition*

Vermont defines physical therapy as "evaluation and treatment of any person by the employment of effective properties of physical measures . . . ." There is no mention of referral in any section. It goes on to say "physical therapy includes, but is not limited to, the performance of specialized tests, administration of specialized therapeutic procedures, development of treatment plans with licensed health care professionals acting within the scope of their practice and establishment and modification of physical therapy programs for patients."

In the section detailing unprofessional conduct such conduct includes: practicing beyond the scope permitted by law, accepting and performing responsibilities one is not competent to perform, and performing services not authorized by the consumer.

### *Discussion*

Here is another state that has a statute that is silent on the question of direct access, though the implication from the requirement that physical therapists may develop treatment plans with licensed health care professionals is that a prior referral is needed for treatment.

## **Virginia** Chapter 34.1

### *Statutory Definition*

Under Virginia law "Practice of physical therapy" means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization."

The Virginia law goes on to note that "after completing a three-year period of active practice upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry or dental surgery, a physical therapist may treat a patient for no more than fourteen consecutive calendar days without a referral under the following conditions: (i) the patient has previously been referred to a physical therapist for physical therapy services by a licensed doctor of medicine, osteopathy, chiropractic, podiatry or dental surgery; (ii) the patient's referral for physical therapy was made within two years from the date the physical therapist implements a program of physical therapy treatment without referral and direction; (iii) the physical therapy being provided to the patient without referral and direction is for the same injury, disease or condition as indicated in the referral of the licensed doctor of medicine, osteopathy, chiropractic, podiatry or dental surgery; and

(iv) the physical therapist notifies the practitioner identified by the patient no later than three days after treatment commences. Treatment for more than fourteen consecutive calendar days of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery.”

### *Discussion*

The Virginia law clearly allows PTs to treat patients without a physician referral under limited circumstances: The PT must have practiced for three years, the patient was referred to a PT for the same injury within the last two years, the PT notifies the patient’s physician within three days and treatment lasts less than fourteen days.

## **Washington** Title 18.74

### *Statutory Definition*

In Washington physical therapy is defined as the "the treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, cold, air, light, water, electricity, sound, massage, and therapeutic exercise." It also includes the "performance of treatments on the basis of test findings after consultation with and periodic review by an authorized health care practitioner except as provided in [RCW 18.74.012](#)."

Section 18.74.012 states "notwithstanding the provisions of [RCW 18.74.010](#), a consultation and periodic review by an authorized health care practitioner is not required for treatment of neuromuscular or musculoskeletal conditions: PROVIDED, That a physical therapist may only provide treatment utilizing orthoses that support, align, prevent, or correct any structural problems intrinsic to the foot or ankle by referral or consultation from an authorized health care practitioner."

The next section requires a referral to a health care practitioner if "symptoms or conditions are present which require services beyond the scope of their practice or for which physical therapy is contraindicated."

The administrative regulations include a definition of consultation as "a communication regarding a patient's evaluation and proposed treatment plan with an authorized health care practitioner." Another section states "direct referral of a patient by an authorized health care practitioner may be by telephone, letter, or in person . . . ."

### *Discussion*

Under this statute a referral or consultation is always needed to utilize orthoses or correct structural problems of the foot and ankle. Consultation or periodic review are not needed for treatment of neuromuscular or musculoskeletal conditions. Both these terms, consultation and periodic review, deal with actions after the patient has arrived at the PTs. Under the definition a consultation is a communications regarding the patient's evaluation and proposed treatment plan which take place

after the PT has looked at the patient. It does not state whether the patient must obtain a referral before their visit to the PT.

## **West Virginia** Chapter 30-20

### *Statutory Definition*

West Virginia is another state that fails to mention if referrals are required for access to treatment in its statute. The statute defines physical therapy as "the therapeutic treatment of any person . . . , for the purpose of correcting or alleviating any physical or mental condition . . . , and the performance of neuro-muscular-skeletal tests and measurements as an aid in diagnosis, evaluation or determination of the existence of and the extent of any body malfunction: *Provided*, That electromyography examination and electrodiagnostic studies other than the determination of chronaxia and strength duration curves shall not be performed except under the supervision of a physician electromyographer and electrodiagnostician. Physical therapy does not include the use of radiology and radium for diagnostic and therapeutic purposes, or the use of electricity for surgical purposes, including cauterization."

### *Discussion*

While discussing what acts must be performed under the supervision of a physician the statute is silent on the question of whether the other treatments allowed under the definition may be performed without a referral from a physician.

## **Wisconsin** Chapter 448.50

### *Statutory Definition*

Wisconsin law states that "a person may practice physical therapy only upon the written referral of a physician. . . . Written referral is not required if a physical therapist provides services in schools to children with disabilities . . . ; provides services as part of a home health care agency; provides services to a patient in a nursing home pursuant to the patient's plan of care; provides services related to athletic activities, conditioning or injury prevention; or provides services to an individual for a previously diagnosed medical condition after informing the individual's physician, chiropractor, dentist or podiatrist who made the diagnosis. The affiliated credentialing board may promulgate rules establishing additional services that are excepted from the written referral requirements of this subsection."

The Physical Therapy Board in Wisconsin has promulgated a rule whereby, "a written referral is not required to provide the following services: conditioning, injury prevention and application of biomechanics, and treatment of musculoskeletal injuries with the exception of acute fractures soft tissue avulsions where other medical interventions may be indicated, related to the work, home, leisure, recreational and educational environments."

### *Discussion*

In Wisconsin there is a statutory requirement for treatment only upon a referral, but there are statutory and administrative exceptions to the general rule. These exceptions seem broad and include "treatment of musculoskeletal injuries with the exception of acute fractures . . . ."

## **Wyoming** Section 33-25-102

### *Statutory Definition*

The statute states: "Except as provided in this subsection, a physical therapist with a master's degree, or a bachelor's degree with five (5) years of clinical experience may initiate physical therapy treatment for a new or recurring injury with or without a prescription from a licensed physician including doctor of osteopathy, podiatrist, advanced practitioner of nursing, dentist, chiropractor or physician assistant. Nothing in this subsection shall be construed to preclude a physical therapist from treating a chronic or recurring injury or condition without a prescription, provided that the patient or client was previously diagnosed and prescribed physical therapy treatment within the previous year by a health care provider identified in this subsection and the treatment is directly related to the original prescribed care. Without a prescription, a physical therapist is prohibited from initiating physical therapy treatment for children under the age of twelve (12) years, unless the child is to receive physical therapy treatment under an individualized education program or an individualized family services plan. A physical therapist shall refer the patient or client to a licensed physician including doctor of osteopathy, podiatrist, advanced practitioner of nursing, dentist, chiropractor or physician assistant, as appropriate, when:

(i) The physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of physical therapy practice;

(ii) Physical therapy is contraindicated; or

(iii) Except for patients or clients participating in general exercise or fitness programs or receiving physical therapy services under an individualized education program or an individualized family services plan, the patient or client has received physical therapy services without a prescription for twelve (12) visits or for a thirty (30) day period, whichever occurs earlier, and further services may be necessary."

### *Discussion*

It is clear that PTs can treat without a referral if they have a Masters Degree or five years experience for up to twelve visits or thirty days whichever comes first.

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In bill text the following has special meaning

underline denotes added text

~~struck out text denotes deleted text~~

Georgia 145th General Assembly --  
 1999 GA H 1045  
 Introduced  
 03/22/1999

1999-00 Regular Session

Hudson  
 HB 1045

LC 11

9855/1

**A BILL TO BE ENTITLED AN ACT**

To amend Chapter 33 of Title 43 of the Official Code of Georgia Annotated, the "Georgia Physical Therapy Act," so as to change the provisions relating to definitions, practice of physical therapy and physiotherapy and use of certain words relating thereto; to change the provisions regarding disciplinary sanctions; to repeal conflicting laws; and for other purposes.

**BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:**

**SECTION 1.**

Chapter 33 of Title 43 of the Official Code of Georgia Annotated, the "Georgia Physical Therapy Act," is amended by striking paragraph (7) of Code Section 43-33-3, relating to definitions, and inserting in its place the following:

"(7) 'Physical therapy' or 'physiotherapy' means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(7.1) 'Practice of physical therapy' means the examination, treatment, ~~intervention,~~ and instruction of human beings to detect, assess, prevent, correct, alleviate, ~~rehabilitate,~~ and limit physical disability, bodily malfunction and pain from injury, disease, and any other bodily and mental conditions and includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices, for ~~preventative~~ preventive and therapeutic purposes; and the provision of consultative, educational, and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain."

## SECTION 2.

Said chapter is further amended by striking the introductory language immediately preceding the designated paragraphs of Code Section 43-33-11, relating to licenses and permissible titles, and inserting in its place the following:

"A physical therapist shall display either the title 'physical therapist' or the abbreviation 'P.T.' on a name tag or other similar form of identification during times when such person is providing direct patient care. A physical therapist assistant shall display either the title 'physical therapist assistant' or the abbreviation 'P.T.A.' on a name tag or other similar form of identification during times when such person is providing direct patient care. A physical therapy aide shall be required to display the title 'physical therapy aide' on a name tag or other similar form of identification during times when such person is assisting a licensee. No person shall practice as a physical therapist or function as a physical therapist assistant nor hold himself or herself out as being able to practice as a physical therapist or function as a physical therapist assistant or as ~~providing~~ practicing physical therapy or physiotherapy or use the initials P.T. or P.T.A. in conjunction therewith or use any word or title to induce the belief that he or she is engaged in the practice of physical therapy unless he or she holds a license and otherwise complies with the provisions of this chapter and the rules and regulations adopted by the board. Nothing in this Code section shall be construed as preventing or restricting the practice, services, or activities of:".

## SECTION 3.

Said chapter is further amended by striking paragraph (1) of subsection (a) of Code Section 43-33-18, relating to disciplinary sanctions, and inserting in its place the following:

"(1) Implemented a program of physical therapy ~~treatment without consultation with an appropriate licensed practitioner of the healing arts, or in the case of practice as a physical therapist assistant, practiced other than under the supervision and direction of a licensed physical therapist;~~ intervention: (A) Not consistent with prevailing standards of practice or the code of ethics established by the board; or

(B) Without consultation with an appropriate licensed practitioner of the healing arts unless such physical therapist:

(i) Has at least two years' experience as a licensed physical therapist;

(ii) Has completed all continuing competency requirements established by the board;  
and

(iii) Refrains from implementing such a program without consultation when:

(I) Signs and symptoms of the patient are present that would require treatment beyond the scope of physical therapy practice;

(II) Physical therapy is contraindicated; or

(III) Thirty days have passed since the initial physical therapy treatment.

(1.1) Practiced as a physical therapist assistant other than under the supervision and direction of a licensed physical therapist; "

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.

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43-33-18 G

\*\*\* CODE SECTION \*\*\* 09/12/00

43-33-18.

(a) The board shall have authority to refuse to grant or restore a license to an applicant or to discipline a physical therapist or physical therapist assistant licensed under this chapter or any antecedent law upon a finding by the board that the licensee or applicant has:

(1) Implemented a program of physical therapy treatment without consultation with an appropriate licensed practitioner of the healing arts, or in the case of practice as a physical therapist assistant, practiced other than under the supervision and direction of a licensed physical therapist;

(2) Displayed an inability or has become unable to practice as a physical therapist or as a physical therapist assistant with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition:

(A) In enforcing this paragraph the board may, upon reasonable grounds, require a licensee or applicant to submit to a mental or physical examination by an appropriate practitioner of the healing arts designated by the board. The expense of such mental or physical examination shall be borne by the licensee or applicant. The results of such examination shall be admissible in any hearing before the board, notwithstanding any claim of privilege under a contrary rule of law or statute, including, but not limited to Code Section 24-9-21. Every person who shall accept the privilege of practicing physical therapy in this state or who shall file an application for a license to practice physical therapy in this state shall be deemed to have given his or her consent to submit to such mental or physical examination and to have waived all objections to the admissibility of the results in any hearing before the board upon the grounds that the same constitutes a privileged communication. If a licensee or applicant fails to submit to such an examination when properly directed to do so by the board, unless such failure was due to circumstances beyond his or her control, the board may enter a final order upon proper notice, hearing, and proof of such refusal. Any licensee or applicant who is prohibited from practicing physical therapy under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate to the board that he or she can resume or begin the practice of physical therapy with reasonable skill and safety to patients;

(B) For the purposes of this paragraph, the board may, upon reasonable grounds, obtain any and all records relating to the mental or physical condition of a licensee or applicant, including psychiatric records; and such records shall be admissible in any hearing before the board, notwithstanding any privilege under a contrary rule of law or statute, including, but not limited to, Code Section 24-9-21. Every person who shall accept the privilege of practicing physical therapy in this state or who shall file an application to practice physical therapy in this state shall be deemed to have given his or her

<http://www.gaaet.org/cgi-bin/pub/ocode/ocgsearch?docname=OCode/G/43/33/18>

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10/17/00

In bill text the following has special meaning underline  
denotes added text  
~~struck out text denotes deleted text~~

Connecticut 2000 Regular Session of the General Assembly  
 2000 CT H 5790  
 Introduced 02/29/2000  
 Committee on Public Health

STATE OF CONNECTICUT

General Assembly

Raised Bill No. 5790

February Session, 2000

LCO No. 2089

Referred to Committee on Public Health

Introduced by: (PH)

An Act Concerning Direct Access To Physical Therapy.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 20-73 of the general statutes, as amended by section 24 of public act 99-102, is repealed and the following is substituted in lieu thereof:

(a) No person may practice as a physical therapist unless licensed pursuant to this chapter. No person may use the term "Registered Physical Therapist", "Licensed Physical Therapist" or "Physical Therapist" or the letters "R.P.T.", "L.P.T." or any other letters, words or insignia indicating or implying licensure as a physical therapist in this state unless the person is so licensed. The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist ~~upon the oral or written referral of~~

A physical therapist shall make a written or oral referral to a person licensed in this state or in a bordering state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, podiatry, natureopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a, ~~as amended,~~ or a physician assistant licensed to prescribe in accordance with section 20-12d, ~~as amended,~~ of any person who has a complaint of pain or loss of function whose symptoms have not improved for a period of forty-five days from the initial evaluation or who has any physical or medical condition that would constitute a contraindication for physical therapy or that may require evaluation or treatment beyond the scope of physical therapy. Any person who violates the provisions of this section or who obtains or attempts to obtain licensure as a physical therapist by any wilful misrepresentation or any fraudulent representation shall be fined not more than five hundred dollars or imprisoned not more than five years, or both. A physical therapist or dentist who violates the provisions of this section shall be subject to licensure revocation in the same manner as is provided under section 19a-17, or in the case of a healing arts practitioner, section 20-45. For purposes of this section, each instance of patient contact or consultation in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section.

(b) Each physical therapy assistant who is assisting in the practice of physical therapy under the supervision of a licensed physical therapist, as defined in section 20-66, as amended, shall, upon payment of an application fee of twenty-five dollars, register with the Department of Public Health on a form furnished by the department, giving ~~his~~ such physical therapy assistant's name in full, ~~his~~ residence and business addresses and such other information as the department requests. Each physical therapy assistant shall notify the department in writing within thirty days of any change in ~~his~~ such physical therapy assistant's name or residence or business addresses. A physical therapy assistant shall not practice physical therapy assisting without registering with the department pursuant to this section. The commissioner may, upon receipt of notification and investigation, assess a civil penalty of not more than one hundred dollars against any physical therapy assistant who has practiced physical therapy assisting without first registering with ~~said~~ the department.

Statement of Purpose:

To provide for direct access to physical therapy and to make technical changes.

<b>STATE and FEDERAL LEGISLATION</b>	<b>STATE and FEDERAL REGULATIONS</b>	<b>NEWS / REFERENCE</b>	<b>CON</b>
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after passing such examination before being eligible for licensure.

(P.A. 73-579, S. 6; P.A. 80-336, S. 2; P.A. 81-473, S. 17, 43; P.A. 82-472, S. 77, 183.)

History: P.A. 80-336 replaced requirements that evidence be produced that school attended is recognized by member organization of world confederation for physical therapy and that courses taken comply with those required by council on medical education of American Medical Association with statement that "requirements for graduation are equal to those required of graduates of approved United States schools of therapy"; P.A. 81-473 substituted term "licensure" for "registration." and modified application procedure and requirements for licensure to conform with changes made in other health professions under process of sunset review begun in 1980; P.A. 82-472 made a technical change.

### **Sec. 20-71. Licensure without examination.**

The department may issue a license without examination, on payment of a fee of two hundred twenty-five dollars, to an applicant who is a physical therapist registered or licensed under the laws of any other state or territory of the United States, any province of Canada or any other country, if the requirements for registration or licensure of physical therapists in such state, territory, province or country were, at the time of application, similar to or higher than the requirements in force in this state.

(1949 Rev., S. 4404; 1953, S. 2207d; 1959, P.A. 575, S. 3; 616, S. 22; P.A. 77-614, S. 323, 385, 610; P.A. 81-473, S. 18, 43; P.A. 89-251, S. 80, 203; May Sp. Sess. P.A. 92-6, S. 21, 117; P.A. 93-381, S. 9, 39; P.A. 95-271, S. 27, 40.) History: 1959 acts increased fee in Subsec. (a) from ten dollars and added Subsec. (b); P.A. 77-614 replaced department of health with department of health services and required that qualifying examination be acceptable to commissioner of health services as well as to board of examiners in Subsec. (b), effective January 1, 1979; P.A. 81-473 amended section to permit the department, with the consent of the board, to set fees for licensure by endorsement and to conform licensing procedures with those of other health professions under sunset review process begun in 1980; P.A. 89-251 set the application fee at one hundred fifty dollars, where previously fee was set by department with board's consent; May Sp. Sess. P.A. 92-6 raised license fee from one hundred fifty to two hundred twenty-five dollars; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-271 deleted the requirement that the foreign state, etc., grant reciprocity, deleted former Subsec. (b) re licensure without examination based on certain schooling and made a technical change.

### **Sec. 20-72. List of registrants.**

Section 20-72 is repealed.

(1953, S. 2211d; 1963, P.A. 143, S. 2.)

<http://www.cslnet.ctstateu.edu/statutes/title20/t20-p9.htm>

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**Sec. 20-73. Use of title "Registered Physical Therapist" or "Licensed Physical Therapist".**

Fraud in obtaining registration. Practice regulated. Revocation of license. (a) No person who is not licensed by the Department of Public Health as a physical therapist shall practice or hold himself out as authorized to practice physical therapy as defined in section 20-66, or represent himself as being so registered or licensed or use in connection with his name the term "Registered Physical Therapist", "Licensed Physical Therapist" or "Physical Therapist" or the letters "R.P.T.", "L.P.T." or any other letters, words or insignia indicating or implying that he is a licensed physical therapist in this state. The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist upon the oral or written referral of a person licensed in this state or in a bordering state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, osteopathy, podiatry, natureopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d. Any person who violates the provisions of this section or who obtains or attempts to obtain licensure as a physical therapist by any wilful misrepresentation or any fraudulent representation shall be fined not more than five hundred dollars or imprisoned not more than five years, or both. A physical therapist or dentist who violates the provisions of this section shall be subject to revocation of his license in the same manner as is provided under section 19a-17, or in the case of a healing arts practitioner, section 20-45. For purposes of this section each instance of patient contact or consultation that is in violation of any provision of this section shall constitute a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section. (b) Each physical therapy assistant who is assisting in the practice of physical therapy under the supervision of a licensed physical therapist, as defined in section 20-66, shall, upon payment of an application fee of twenty-five dollars, register with the Department of Public Health on a form furnished by the department, giving his name in full, his residence and business addresses and such other information as the department requests. Each physical therapy assistant shall notify the department in writing within thirty days of any change in his name or residence or

<http://www.cslnet.ctstateu.edu/statutes/title20/t20-p9.htm>

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business addresses. A physical therapy assistant shall not practice physical therapy assisting without registering with the department pursuant to this section. The commissioner may, upon receipt of notification and investigation, assess a civil penalty of not more than one hundred dollars against any physical therapy assistant who has practiced physical therapy assisting without first registering with said department.

(1949 Rev., S.4407,4409; 1953, S. 2209d, 2210d; 1959, P.A. 575, S. 5; P.A. 73-579, S. 3; P.A. 76-276, S. 18,22;P.& 77-614,S. 323, 610; P.A. 80-336, S. 3; P.A. 81-473, S. 19, 43; P.A. 84-526, S. 6; P.A. 93-55, S. 2; 93-381, S. 9, 39; P.A. 94-213\_S. 3; P.A., 95-257, S. 12, 21, 58; 95-299, S. 3.)

History: 1959 act changed technical language, added provision which refers to Sec. 20-66 and reference to "Physical Therapist" and deleted stipulation that persons who are registered may so hold themselves out; P.A. 73-579 allowed therapist to practice under direction of person licensed to practice osteopathy; P.A. 76-276 substituted reference to Sec. 20-48 for repealed Sec. 20-48a and added reference to sections specifically applicable to revocation of physician's license; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; P.A. 80-336 rephrased provision setting forth conditions for practice of physical therapy and allowed practice under order or referral of practitioners in bordering states if licensure requirements of such state are approved and included podiatry, natureopathy, chiropractic and dentistry practitioners among those who may supervise therapists; P.A. 81-473 amended section to reflect change from registration to licensure; P.A. 84-526 amended section by changing penalty for violation of any provision of section to a fine of not more than five hundred dollars or imprisonment of not more than five years, and added provisions that each instance of patient contact or consultation shall constitute a separate offense and failure to renew license in timely manner is not a violation for purposes of section; P.A. 93-55 made technical changes; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 94-213 added reference to prescriptions by advanced practice registered nurses and physician assistants; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health. effective July 1, 1995; P.A. 95-299 divided section into Subdivs. and added provisions to allow the registration of physical therapy assistants.

*Former statute cited. 141 C. 288.*

### **Sec. 20-73a. Charges against registrant, verification, hearing.**

Grounds for disciplinary action. Appeal. The Board of Examiners for Physical Therapists shall

<http://www.cslnet.ctstateu.edu/statutes/title20/t20-p9.htm>

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**TAB TWO**

## **EDUCATION AND TRAINING**

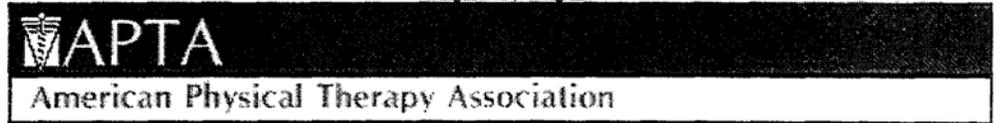
- I. The Physical Therapist: A Professional Profile  
*American Physical Therapy Association*
- II. Physical Therapy Education  
*American Physical Therapy Association*
- III. Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists  
*American Physical Therapy Association*
- IV. Physical Therapy Curriculum *University of New Mexico*
- V. Physical Therapy Course Descriptions *University of Delaware*
- VI. Physical Therapy Curriculum *Northern Illinois University*



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- *The Physical Therapist*
- *The Physical Therapist*
- *The Physical Therapist Assistant*
- *PT Demographics*
- *PTA Demographics*



APTA Background Sheet

charrison, 3/11/99

**The Physical Therapist: A Professional Profile****WHO ARE PHYSICAL THERAPISTS?**

Physical therapists, or PTs, are health care professionals who evaluate and treat people with health problems resulting from injury or disease. PTs assess joint motion, muscle strength and endurance, function of heart and lungs, and performance of activities required in daily living, among other responsibilities. Treatment includes therapeutic exercise, cardiovascular endurance training, and training in activities of daily living. More than 90,000 physical therapists practice in the US today, treating nearly 1 million people every day. Average annual income is approximately \$55,000, depending on geographic location and practice setting. Physical therapists have the potential to earn more than \$100,000 annually.

**WHERE DO PHYSICAL THERAPISTS PRACTICE?**

Although many physical therapists practice in acute care or sub-acute care hospitals, more than 65% practice in private physical therapy offices, community health centers, industrial health centers, sports facilities, rehabilitation centers, nursing homes, home health agencies, schools or pediatric centers; work in research institutions; or teach in colleges and universities.

**WHAT ARE THE EDUCATIONAL REQUIREMENTS FOR BECOMING A PT?**

The minimum educational requirement is a 4-year college degree in physical therapy from an accredited education program. However, the majority of programs offer the master's degree in physical therapy and after 2002, post-baccalaureate degrees will be required. Currently, 173 colleges and universities nationwide offer professional education programs in physical therapy.

**WHAT ARE THE LICENSURE REQUIREMENTS FOR BECOMING A PT?**

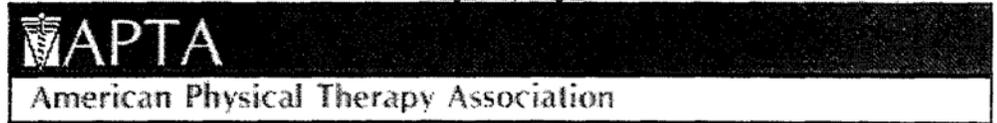
After graduation, candidates must pass a state-administered national exam. Other requirements for physical therapy practice vary from state to state according to physical therapy practice acts or state regulations governing physical therapy. Information may be obtained by contacting your state licensure board. You can link to the Federation here, which will have listing of agencies.

**WHAT IS THE EMPLOYMENT OUTLOOK FOR PHYSICAL THERAPY?**

Throughout the 78-year history of physical therapy in the United States, there has been a shortage of qualified physical therapists. According to a 1997 report, commissioned by the American Physical Therapy Association, there will be a surplus of physical therapists of approximately 2% by the end of 1999.

**More information on a career in physical therapy:** <https://www.apta.org/Consumer/whoareptsptas/profile>

- [Physical Therapy Education FAQ](#)
- [Foundation for Physical Therapy](#)
- [Minority Scholarship Awards](#)



## Physical Therapy Education Frequently Asked Questions

### **Is the status of the physical therapist with a bachelor's degree different from that of a physical therapist with an entry-level master's/doctoral degree?**

The status of the entry-level physical therapist with a baccalaureate or post-baccalaureate degree is the same. The essential requirements for practice are graduation from an accredited professional (entry-level) physical therapist program and passing the national licensure examination. All professional (entry-level) programs are designed to provide a broad physical therapy background regardless of the degree offered; however, programs may emphasize certain areas as a result of a specific program mission or because of individual faculty strengths.

### **Why does APTA advocate a post-baccalaureate degree?**

A post-baccalaureate degree allows the student to obtain a broad background in the liberal arts and provides time for students to integrate the significant amount of material included in a physical therapy curriculum. Also, for those who currently possess a bachelor's degree in another area, it is a logical choice to progress to a post-baccalaureate degree.

Over the years the volume of scientific technology and literature included in physical therapist education programs has grown well beyond what can be reasonably included in a baccalaureate degree program. APTA believes that a post-baccalaureate program more adequately prepares the graduate to meet the expectations of the profession and the health care needs of society.

**What is the future of baccalaureate professional (entry-level) education?** Since 1979, the profession has consistently advocated the development of post-baccalaureate professional educational programs. As of January 1, 2002, the Commission on Accreditation in Physical Therapy Education (CAPTE) will no longer accredit baccalaureate professional programs.

### **If I have a bachelor's degree in physical therapy, will I be required to get a graduate degree in the future?**

No. However, there is an expectation that physical therapists will continue to learn throughout their professional careers. There are numerous opportunities for post-professional education, some of which may be required to maintain licensure. Also, keep in mind state licensure and practice acts are subject to change.

### **Are there any professional (entry-level) doctoral programs available?**

Yes. The accredited professional (entry-level) doctoral programs are identified by the key code (D6) on the physical therapist program list. There continues to be an increase in the number of universities considering the transition to a doctoral program.

### **What are the differences between a professional (entry-level) master's degree program and a professional? (Entry-level doctoral program?)**

Both levels are accredited by CAPTE using the Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists. The institution determines the degree to be offered.

### **Is there a ranking of PT and PTA programs?**

APTA does not rank programs. Physical therapy educational programs are accredited by CAPTE, which assures quality in physical therapy education. Graduation from an accredited program is currently required for eligibility to sit for the licensure examination for physical therapists and for physical therapist assistants in those states in which licensure is required.

### **What factors can one use in deciding on a school?**

The decision to attend a physical therapy program is a very personal one, which must be made on the basis of a variety of factors, such as:

- Geographic location and size of the school
- Cost
- Class size
- Licensure pass rates
- Employability
- Faculty composition and cohesiveness (years working together)
- Degree awarded; design and length of curriculum
- In an effort to compare the above factors, you may wish to:
- Survey current students and recent graduates of the program
- Interview employers who hire graduates and ask about program strengths and weaknesses

**What can students do to enhance chances of admission to a PT program?** Candidates should have a high overall grade point average (GPA) and a high GPA in prerequisite course work (in 1993, the majority of applicants to PT programs reported GPAs of 3.0 or higher out of a 4.0 score). Admission officers also look favorably on an applicant's volunteer experience as a physical therapy aide, letters of recommendation from physical therapists or science teachers, and excellent writing and interpersonal skills. The physical therapist education program is a full-time commitment.

### **Is the physical therapist assistant program a stepping-stone to a physical therapist program?**

No. The physical therapist assistant curriculum differs from that of the physical therapist, and does not provide the needed prerequisites required for physical therapist education. There are accredited programs in California, and Ohio designed to allow experienced physical therapist assistants to continue working while attending a physical therapist master's degree program on the weekends.

### **Where can I find financial aid?**

Purchase APTA's **Resource Guide on Financial Assistance** (includes information on minority scholarships) from APTA's Service Center (800/999-2782, ext 3395) or order from APTA's **Online Catalog**. Additional resources are available from the office of financial aid at the school of interest, the public library, and the **National Clearinghouse at the Professions Information Center at the Council for Exceptional Children**, 1920 Association Drive, Reston, VA 22091, 703/264-9476, or 800/641-7824. Other sources include various Internet sites: **The Financial Aid Information Page**, **Fastweb**, **US Department of Education**, **Direct Loans**, **Project EASI**, **IRS Education Tax Credit** Information and **College Parents of America** (CPA).

### **For further information:**

- See *A. Future in Physical Therapy* This online brochure is also available in paper format and can be ordered from APTA's **Online Catalog**, through APTA's Service Center (800/999-2782, ext 3395), or through APTA's Fax-on-Demand service: 800/399-2782).
- Check out **APTA's Web site (www.apta.org)**.
- Purchase the **Directory of Physical Therapy Education Programs** (order from the **Online Resource Catalog** or through APTA's Service Center (800/999-2782, ext 3395).
- Contact the individual schools for detailed information. Find the accredited and developing lists of educational programs with phone numbers and addresses on the PT\_Education/School Listings Index page.

- Visit the DPT FAQ on this Web site.

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*for: laboratory experiences; teaching; research; and supportive activities, such as preparation of instructional materials, correspondence, administrative materials, and special projects. The program is responsible for assuring that these supplies and equipment are reflective of contemporary practice in physical therapy, are sufficient in amount, and are available when needed.*

**2.8.2. The program has, or has use of, equipment and materials for core faculty to fulfill their role as scholars.**

*Core faculty is expected to contribute to the scholarship of the profession and to the mission of the institution. They therefore must have adequate equipment and materials that are appropriate for their scholarly needs. In addition, technological support and equipment are adequate to meet the needs of the core faculty to conduct research and other scholarly activities approved by the program and institution.*

**Section 3: Curriculum Development and Content: Preamble**

**A curriculum is a plan for learning, designed by the program faculty in consultation with practitioners and members of communities of interest, to achieve explicit educational goals and objectives for preparation of a physical therapist. In addition to preparing practitioners, one goal of physical therapy education is to build on the liberal education of the student by incorporating the concepts of responsible citizenship into the professional curriculum. The curriculum sets forth the knowledge, skills, attitudes, and values needed to achieve these goals.**

**The professional program is built on a foundation of liberal arts, and social and basic sciences. Course work within the professional curriculum includes a balance of foundational and clinical sciences; critical inquiry; clinical practice; and studies of society, health care delivery, and physical therapy practice. The educational philosophy and values of the institution, the program, and the individuals who teach in it and the knowledge of and beliefs about learning are central aspects of the curriculum.**

**The educational outcomes are entry-level and are based on practice expectations that are congruent with and reflect current physical therapy practice, emerging trends in health care delivery, and advances in physical therapy theory and technology.**

**3.1. Core faculty members assume primary responsibility for curriculum development with input from all program faculty members as well as from students enrolled in the program.**

*Curriculum development is the responsibility of the core faculty. The core faculty develops the curriculum using information about the contemporary practice of physical therapy; standards of practice; and, current literature, documents, publications and other resources related to the profession, physical therapy professional education, and educational theory. Input from program faculty, the clinical community, and students is utilized in this development process.*

### **3.2. There is a formal curriculum plan.**

*The curricular plan developed by the faculty is documented and includes the components listed below.*

#### **3.2.1. The curriculum plan states the philosophy and the principles and values of the program and reflects the nature of professional education in physical therapy.**

*There is a formal statement of the philosophy, principles, and values on which the curriculum plan is based.*

#### **3.2.2. The curriculum plan includes the conceptual bases of the curriculum, the educational principles on which the curriculum is built, and statements of the expected student outcomes.**

*The conceptual bases of the curriculum are apparent in the description of the curriculum plan. The curriculum plan and expected student outcomes are formally presented and understood by all communities of interest including students.*

#### **3.2.3. The curriculum plan includes a series of organized, sequential and integrated learning experiences.**

*The curriculum design is a well-planned and organized approach to the accomplishment of the program's mission utilizing sound principles of education. The comprehensive curriculum plan is designed in such a manner that the performance of the expected student outcomes is facilitated. Throughout the curriculum, opportunities are provided for students to explore areas of interest or to pursue in greater depth topics in which they wish to become more proficient or knowledgeable.*

*The comprehensive curriculum plan includes the development of instructional courses or units (both required and elective; both academic and clinical), which will be used in the implementation of the curriculum design. The didactic content of the instructional courses or units and the learning experiences should be those, which will facilitate the attainment of the expected student outcomes.*

#### **3.2.4. The curriculum plan includes instructional units with objectives stated in behavioral terms that are reflective of the depth and breadth of the content and of the level of student performance expected.**

*The objectives of the instructional courses, units, and learning experiences should be stated in terms of what the student will be able to do or demonstrate upon successful completion of each course, unit, or experience. There should be a variety of effective methods, reflecting specific course didactic and/or skill content, by which the student's achievement of the objectives and competencies can be measured.*

### **3.3. The curriculum encompasses a variety of instructional methods selected to maximize learning.**

*There is evidence of consideration of a variety of instructional methods. Methods employed are chosen based on the philosophy of the curriculum plan, the content, the needs of the learners, and the defined outcomes expected of the students.*

**3.4. Faculty use evaluation processes to determine whether students are competent and safe to progress through the curriculum, including the clinical education component.**

*The program faculty utilizes a variety of effective methods to assess student competence, safety, and readiness to progress through the curriculum. Evaluation of student performance occurs regularly. At a minimum, performance evaluation must occur at the end of each term of the curriculum and include assessment of performance in both academic and clinical course work. Student progression is based on demonstrated competencies. Students receive regular formative feedback about their performance.*

**3.5. Clinical experiences selected by the program reflect a variety of practice settings and provide the students with professional role modeling, and access to patients representative of those commonly seen in practice.**

*Clinical experiences required of students are planned based on student progression in the curriculum and are based on the type of supervision required, the variety of experiences needed, and the complexity of clinical problem solving to be accomplished. In planning clinical education programs, the collective experiences provided allow opportunities in patient care and teaching, as well as opportunities for students to learn through observation of and participation in administrative activities, quality assurance activities, clinical research, and supervision of physical therapist assistants and other supportive personnel.*

**3.6. The clinical experiences selected by the program ensure that the type and amount of clinical supervision are appropriate for the student's experience, ability and point of progression in the program, and that appropriate guidance and feedback are provided to the student.**

*The program provides a formally designed program of clinical education coordinated with all course work in the program. This is communicated to the clinical education faculty to facilitate their planning of appropriate clinical experiences for students and to ensure that the clinical education faculty appreciates the level of supervision needed by individual students at various phases throughout the curriculum. The program establishes policies and procedures with the clinical education faculty, which assure that students receive planned guidance and formative and regular assessment of their clinical performance.*

**3.7. Physical therapy education is built on a balance of course work in social sciences, humanities, and natural sciences, that is appropriate in depth and breadth, to develop the ability in students to think independently, to weigh values, to understand fundamental theory, and to develop skills for clinical practice, including critical thinking and communication.**

*Prerequisite course work for the professional program assures that the student has acquired a comprehensive background in the liberal arts and sciences. This includes study in social sciences, humanities and natural sciences, which results in a broadly educated student. Students enter the professional program with skills which include being able to think independently, demonstrate problem solving techniques for solving complex and simple problems, weigh values and set priorities, understand fundamental theory, exhibit responsible social behavior, demonstrate professional collegiality and good citizenship, and effectively communicate both orally and in writing as expected of all students. These attributes are typically exemplified by students who have a Baccalaureate degree.*

**3.8. The curriculum incorporates a combination of didactic, clinical, and research learning experiences that are reflective of contemporary physical therapy practice, and includes:**

**3.8.1. Instruction in the foundational sciences, including laboratory or other practical experiences involving quantitative and qualitative observations;**

*Learning experiences are designed to 1) provide basic know/edge in the sciences related to normal and abnormal human structure, function, and response to injury and disease; 2) enhance the students' ability to make quantitative and qualitative observations; and, 3) facilitate understanding of the clinical sciences.*

**3.8.2. Instruction in the clinical sciences, including laboratory or other practical experiences;**

*Theory and practical learning experiences are designed to 1) build on the foundational sciences, 2) develop the know/edge necessary to generate a diagnosis, prognosis and plan of care; and 3) develop the know/edge necessary for understanding, presenting rationale for, and applying intervention strategies.*

**3.8.3. Learning experiences designed to achieve educational outcomes required for initial practice of the profession of physical therapy. Graduates of the program are prepared, in the following areas, to:**

**Communication**

**3.8.3.1. Expressively and receptively communicate with all individuals when engaged in physical therapy practice, research, and education, including patients, clients, families, care givers, practitioners, consumers, payers, and policy makers.**

## Individual and Cultural Differences

**3.8.3.2. Incorporate an understanding of the implications of individual and cultural differences when engaged in physical therapy practice, research, and education.**

## Professional Behavior

**3.8.3.3. Demonstrate professional behaviors in all interactions with patients, clients, families, care givers, other health care providers, students, other consumers, and payers.**

**3.8.3.4. Adhere to legal practice standards, including all federal, state, jurisdiction, and institutional regulations related to patient or client care, and to fiscal management.**

**3.8.3.5. Practice ethical decision-making that is consistent with applicable professional codes of ethics, including the APTA's Code of Ethics.**

**3.8.3.6. Participate in peer assessment activities.**

**3.8.3.7. Participate in clinical education activities.**

## Critical Inquiry and Clinical Decision-making

**3.8.3.8. Participate in the design and implementation of decision-making guidelines.**

**3.8.3.9. Demonstrate clinical decision-making skills, including clinical reasoning, clinical judgment, and reflective practice.**

**3.8.3.10. Evaluate published studies related to physical therapy practice, research, and education.**

**3.8.3.11. Secure and critically evaluate information related to new and established techniques and technology, legislation, policy, and environments related to patient or client care.**

**3.8.3.12. Participate in scholarly activities to contribute to the body of physical therapy knowledge (e.g. case reports, collaborative research).**

## Education

**3.8.3.13. Educate others using a variety of teaching methods that are commensurate with the needs and unique characteristics of the learner.**

[https://www.apta.org/Education/accreditation/evaluativecriteria\\_pt](https://www.apta.org/Education/accreditation/evaluativecriteria_pt)

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## **Professional Development**

**3.8.3.14. Formulate and implement a plan for personal and professional career development based on self-assessment and feedback from others.**

## **Screening**

**3.8.3.15. Determine the need for further examination or consultation by a physical therapist or for referral to another health care professional.**

## **Examination**

**3.8.3.16. Independently examine and re-examine a patient or client by obtaining a pertinent history from the patient or client and from other relevant sources, by performing relevant systems review, and by selecting appropriate age-related tests and measures. Tests and measures (listed alphabetically) include, but are not limited to, the following:**

- a) Aerobic capacity and endurance**
- b) Anthropometric characteristics**
- c) Arousal, mentation, and cognition**
- d) Assistive and adaptive devices**
- e) Community and work (job, school or play) reintegration**
- f) Cranial nerve integrity**
- g) Environmental, home, and work barriers**
- h) Ergonomics and body mechanics**
- i) Gait, assisted locomotion, and balance**
- j) Integumentary integrity**
- k) Joint integrity and mobility**
- l) Motor function**
- m) Muscle performance (including strength, power, and endurance)**
- n) Neuromotor development and sensory integration**
- o) orthotic, protective, and supportive devices**

**p) Pain**

**q) Posture**

**r) Prosthetic requirements**

**s) Range of motion (including muscle length) t) reflex integrity**

**u) Self care and home management (including activities of daily living and instrumental activities of daily living)**

**v) Sensory integrity (including proprioception and kinesthesia)**

**w) Ventilation, respiration, and circulation**

## **Evaluation**

**3.8.3.17. Synthesize examination data to complete the physical therapy evaluation.**

## **Diagnosis**

**3.8.3.18. Engage in the diagnostic process in an efficient manner consistent with the policies and procedures of the practice setting.**

**3.8.3.19. Engage in the diagnostic process to establish differential diagnoses for patients across the lifespan based on evaluation of results of examinations and medical and psychosocial information.**

**3.8.3.20. Take responsibility for communication or discussion of diagnoses or clinical impressions with other practitioners.**

## **Prognosis**

**3.8.3.21. Determine patient or client prognoses based on evaluation of results of examinations and medical and psychosocial information.**

## **Plan of Care**

**3.8.3.22 Collaborate with patients, clients, family members, payers, other professionals, and individuals to determine a realistic and acceptable plan of care.**

**3.8.3.23. Establish goals and functional outcomes that specify expected time duration.**

**3.8.3.24. Define achievable patient or client outcomes within available resources.**

**3.8.3.25. Deliver and manage a plan of care that complies with administrative policies and procedures of the practice environment.**

**3.8.3.26. Monitor and adjust the plan of care in response to patient or client status.**

[https://www.apta.org/Education/accreditation/evaluativecriteria\\_pt](https://www.apta.org/Education/accreditation/evaluativecriteria_pt)

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## **Intervention**

**3.8.3.27. Practice in a safe setting and manner to minimize risk to the patient, client, physical therapist, and others.**

**3.8.3.28. Provide direct physical therapy intervention, including delegation to support personnel when appropriate, to achieve patient or client outcomes based on the examination and on the impairment, functional limitations, and disability. Interventions (listed alphabetically) include, but are not limited to:**

- a) Airway clearance techniques**
- b) Debridement and wound care**
- c) Electrotherapeutic modalities**
- d) Functional training in community and work (job, school or play) reintegration (including instrumental activities of daily living, work hardening, and work conditioning)**
- e) Functional training in self care and home management (including activities of daily living and instrumental activities of daily living)**
- f) Manual therapy techniques**
- g) Patient-related instruction**
- h) Physical agents and mechanical modalities**
- i) Prescription, application, and as appropriate fabrication of adaptive, assistive, orthotic, protective and supportive devices and equipment**
- j) Therapeutic exercise (including aerobic conditioning)**

**3.8.3.29. Provide patient-related instruction to achieve patient outcomes based on impairment, functional limitations, disability and patient satisfaction.**

**3.8.3.30. Complete thorough, accurate, analytically sound, concise, timely, and legible documentation that follows guidelines and specific documentation formats required by the practice setting.**

**3.8.3.31. Take appropriate action in an emergency in any practice setting.**

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## **Outcomes Measurement and Evaluation**

**3.8.3.32. Implement an evaluation of individual or collective outcomes of patients or clients.**

## **Prevention and Wellness**

**3.8.3.33. Identify and assess the health needs of individuals, groups, and communities, including screening, prevention, and wellness programs that are appropriate to physical therapy.**

**3.8.3.34. Promote optimal health by providing information on wellness, disease, impairment, functional limitations, disability, and health risks related to age, gender, culture, and lifestyle.**

## **Management in Various Care Delivery Systems**

**3.8.3.35. Provide primary care to patients with neuromusculoskeletal disorders within the scope of physical therapy practice through collaboration with other members of primary care teams based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.**

**3.8.3.36. Provide care to patients referred by other practitioners, independently or in collaboration with other team members, based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.**

**3.8.3.37. Provide care to patients, in collaboration with other practitioners, in settings supportive of comprehensive and complex services based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.**

**3.8.3.38. Assume responsibility for the management of care based on the patient's or client's goals and expected functional outcomes and on knowledge of one's own and other's capabilities.**

**3.8.3.39. Manage human and material resources and services to provide high quality, efficient physical therapy services based on the plan of care.**

**3.8.3.40. Interact with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient or client care.**

## **Administration**

**3.8.3.41. Delegate physical-therapy-related services to appropriate human resources.**

**3.8.3.42. Supervise and manage support personnel to whom tasks have been delegated.**

**3.8.3.43. Participate in management planning as required by the practice setting.**

**3.8.3.44. Participate in budgeting, billing, and reimbursement activities as required by the practice setting.**

**3.8.3.45. Participate in the implementation of an established marketing plan and related public relations activities as required by the practice setting.**

## **Consultation**

**3.8.3.46. Provide consultation to individuals, businesses, schools, government agencies, or other organizations.**

## **Social Responsibility**

**3.8.3.47. Become involved in professional organizations and activities through membership and service.**

**3.8.3.48. Display professional behaviors as evidenced by the use of time and effort to meet patient or client needs or by providing pro bono services.**

**3.8.3.49. Demonstrate social responsibility, citizenship, and advocacy, including participation in community and human service organizations and activities.**

*The curriculum includes content and learning experiences designed to prepare students to exhibit the above practice expectations upon graduation from the program. The expected student outcomes include those sets of know/edge and skills, which the graduates are prepared to demonstrate upon successful completion of the required academic and clinical portions of the education program. The practice expectations are drawn from the **Normative Model of Physical Therapist Professional Education (1996) and the Guide to Physical Therapist Practice, Volume I (1995, and early drafts of the 1997 revision).***

*In determining the specific content to be included, the program faculty utilizes information about the contemporary practice of physical therapy; standards of practice; and current literature, documents, publications and other resources related to the profession, health care delivery, physical therapy professional education, and educational theory. The Commission recognizes that the documents referenced above are subject to periodic review and revision. In view of the changing nature of health care delivery and of the profession, the Commission expects that the program faculty will keep abreast of any and a// changes in professional physical therapy practice as reflected in future revisions of these documents and will make appropriate adjustments in curricular content and expectations, whether or not these criteria have been formally revised.*

*The program faculty evaluates students in a variety of ways during the academic and clinical education aspects of the program to ascertain each student's preparation for Physical therapy practice.*

### **3.9. The first professional degree for physical therapists is awarded at the post-baccalaureate level at the completion of the physical therapy program.**

*The institution is responsible for naming the degree at the post baccalaureate level that is awarded after the completion of the education program. A program located in an institution that is not a degree granting institution must demonstrate that it has an agreement with one or more accredited institutions that will grant the first degree, at the post-baccalaureate level, to the student upon completion of the physical therapy program.*

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## **Section 4: Program Assessment:**

### **Preamble**

Physical therapy education programs are accountable for an ongoing process of assessment of educational outcomes and for continuous improvement in all aspects of the program.

In judging compliance with the following evaluative criteria, the Commission on Accreditation in Physical Therapy Education and the on-site evaluation team will seek evidence that the program is involved in an on-going effort to determine the effectiveness of the program. The information collected about the performance of program graduates related to the practice expectations of the curriculum as well as evidence that supports the relevance of the program philosophy and the attainment of the program's mission, goals and objectives is obtained through ongoing outcome assessment efforts and used to support future changes in all aspects of the program. The ongoing process of assessment includes collection of information on a regular basis with input from multiple sources and using a variety of methods to gather data.

Although the curriculum must include learning experiences that lead to the attainment of the educational outcomes in Section 3.8.3, the Commission recognizes that the complexity and variety of physical therapy practice is such that program graduates may engage in those activities to varying degrees. The Commission expects that the program will determine the extent to which this variety in graduate practice warrants changes in the program, particularly in light of the need to prepare graduates for practice in any setting or location.

### **4.1. Assessment is part of a systematic and formal approach to continuous improvement. There is an ongoing process of assessment to determine the effectiveness of the program that includes, but is not limited to, the following (listed alphabetically):**

*The program is engaged in collecting information on a regular and ongoing basis. The collection of information uses multiple approaches to assessment and includes data from a variety of sources. Such sources should include but not be limited to: program*

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# Curriculum

**Department of Orthopedics  
Physical Therapy Program**

## PHYSICAL THERAPY CURRICULUM

The philosophy of the Division of Physical Therapy is that the education of you, the physical therapy student, proceeds in an orderly planned sequence and provides experiences that enable you to become an effective learner and sharer of knowledge, develop the skills necessary to coordinate and plan health care services, do research and add to the professional physical therapy body of knowledge, learn effectively to consult and communicate with others, and above all provide caring, compassionate, quality physical therapy services to those in need.

The faculty of the Program in Physical Therapy is committed to a flexible curriculum - one that changes with the needs of the profession and the needs of the students. Major changes such as the transition to post-baccalaureate entry-level education will be a result of many months and years of data collection on needs. Changes in course sequence, addition of courses, or wants within the courses, and changes within a single course may occur more quickly. A major source of information, which contributes to these changes, is feedback from students and graduates of the Program. You will be asked to participate in this process to assess the effectiveness of examinations, written assignments, individual courses and units, including clinical education. We ask you to be diligent in giving us feedback so that we can continue to improve our curriculum.

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We have designed the physical therapy curriculum for you in the following manner to provide optimal learning experiences in an optimal sequence.

### **First Summer Session**

During the first summer session, you will take PT 510 Introduction to Physical Therapy, and PT 521 Human Anatomy.

#### **PT 510 Introduction to Physical Therapy - Burke Gurney**

The purpose of PT 510 is to introduce students to the profession of physical therapy. The course includes a description of the history and development of physical therapy as a profession, including the professional organization; a review of ethical and legal aspects; and methods of assuring that the profession is meeting the needs of the public.

The course also introduces basic educational concepts and learning styles, including determining one's own style, as well as information on verbal and nonverbal communication. The course is a prerequisite for PT 571, 671, 622 and 680.

#### **PT 521 Human Anatomy - Heather Murray**

PT 521 is an intensive study of the structures of the human body; the information presented is fundamental to nearly all aspects of the practice of physical therapy. The primary emphasis is the study of the macroscopic structure of the musculoskeletal, cardiovascular and pulmonary systems; detailed anatomy of the brain and spinal cord will be studied in PT 522 Neuroanatomy. The following areas also will be studied in this course: histology of basic tissues, the gastrointestinal system, the integumentary system, the genitourinary system, and the male and female reproductive system. The course serves as a prerequisite for all future basic sciences and professional course work, especially PT 570 Kinesiology, and PT 552 Evaluative Procedures. Prerequisites for this course are 8 semester hours of human biology, 8 semester hours of anatomy and physiology, 4 semester hours of microbiology, 8 semester hours of physics, 8 semester hours of general chemistry and 4 semester hours of organic or biochemistry.

### **First Fall Semester**

During the first fall semester, you will continue your basic science foundation with PT 551 Clinical Exercise Physiology, PT 541 Survey of Medical Sciences I - Pathology and PT 570 Kinesiology/Functional Anatomy. You will also take the professional courses of PT 501 Therapeutic Exercise I and PT 530 Professional Development and will begin to prepare for clinical experience in PT 571 Clinical Education I.

#### **PT 501 Therapeutic Exercise I - Burke Gurney and Zina Geller**

This course includes information on basic transfers, gait training, and general therapeutic exercise techniques. Basic evaluation techniques such as manual muscle testing and goniometric measurements are also included. A component of this course also deals with soft tissue assessment and treatment techniques,

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including Western massage techniques and soft tissue mobilization. Course material includes the purposes, indications, contraindications, and physiological effects of each type of treatment. An effort is made to apply learning to clinical problems. Prerequisites: PT 521. Corequisites: PT 570, 571, 551 and 541. PT 501 serves as a prerequisite for PT 502, 542, 552, 572, 601, 661, 671, 602, 672, 695 and 675.

### **PT 530 Introduction to Research - Linda McClain (OT Faculty)**

The purpose of this course is to assist physical therapy students to grasp the basic concepts of research (reliability, validity, differences in research designs), to be able to critique and utilize the professional literature at a beginning level of competence, to gain a sense of the process of scientific inquiry, and to develop basic skills in writing in a scientific format. Students are expected to have a basic understanding of statistics before entering the course. It is expected that at the end of the course, students will be prepared to be competent consumers of research. That is, when reading research, the student will be able to critically assess the questions being posed and determine their significance, analyze the appropriateness, strengths and limitations of the methods being used, understand the significance of the date, decipher whether the conclusions are consistent with the results, identify remaining unanswered questions and relate the relevance of the research results to clinical problems. This course essentially serves as a prerequisite for all of the professional courses in that the student is expected to critically review literature during the curriculum as well as throughout their professional [careers](#). PT 530 specifically serves as the foundation for development and completion of the senior research project (PT 631 and 699).

### **PT 541 Survey of Medical Sciences I - Pathology - Pat Burtner (OT Faculty)**

Pathology is the study of disease and disease processes. The goal of this course is to provide the student with a clear picture of the pathophysiology and clinical presentation of common disease entities. The emphasis is on disease processes that are most likely to have manifestations requiring physical therapy intervention. These diseases include: neoplastic, cardiac, pulmonary, musculoskeletal, vascular, renal, infectious, immunological, hematological, and metabolic disorders. Trauma, shock, epidemiology, and specific infectious organism schema such as HIV are also covered. Prerequisite: PT 521. Corequisites: PT 570, 571 and 551. PT 541 serves as a prerequisite for: PT 502, 506, 542, 552, 572, 601, 671, 602, 672 and 695.

### **PT 570 Kinesiology and Functional Anatomy - Ron Andrews**

Kinesiology and Functional Anatomy is an intensive study of human motion. The understanding of human motion is critical for the practicing physical and occupational therapist. The purpose of this course is to provide the framework in functional anatomy, biomechanical principles, and kinesiology. This framework will become the underpinnings for additional course work in clinical methods of assessment and treatment. The introductory section of the course will cover principles of biomechanics, arthrology, tissue mechanics, and principles of measurement. The course will then require students to integrate these principles with functional anatomy to study detailed human movement by region of the body. A final section will cover posture and normal gait. Prerequisite: PT 521 L. Corequisites: PT 501 L, 541, and 551 L. This course acts as a prerequisite for PT 502L, 506L, 542, 552L, 601 L, 671 L and 672L.

**PT 571 Clinical Education I and Seminar - James Dexter, Heather Murray and Zina Geller**

The focus of this course is on PT documentation and clinical communication skills. The student will study the SOAP note format and have opportunities to practice documentation using this format. The course will also address medical terminology using a programmed learning approach. Included also is information on reviewing medical records and a unit on Spanish for medical personnel. This course also includes a unit of problem-based learning intended to allow students to integrate knowledge and clinical skills from other courses, and to foster discussion, independent inquiry and problem solving in relation to patient cases. Ethical issues will be addressed by one lecture. Prerequisite: PT 521. Corequisite: PT 541. This course acts as a prerequisite for PT 572, 622, 671, 672 and 675.

**PT 551 Clinical Exercise Physiology - Burke Gurney**

This course includes principles of exercise physiology as they relate to the various systems of the body, including how pathological conditions affect these systems. There is an emphasis on acute and chronic effects of exercise on the various systems of the body with exercise evaluation and designing specialized exercise programs for effective patient care. It builds on the fundamental organization introduced in basic human physiology, a prerequisite for this program. Prerequisites: 8 semester hours of basic anatomy and physiology and PT 521. Corequisites: PT 501, 541 and 570. PT 551 serves as a prerequisite for PT 502, 552, 572, 601, 402, 671, 672, 695 and 675.

**First Spring Semester**

During the first spring semester, you will continue your science foundation with PT 522 Neuroanatomy and PT 542 Survey of Medical Sciences 11-Orthopaedics. Your professional course work will include PT 552 Evaluative Procedures I, PT 502 Therapeutic Exercise II and PT 506 Therapeutic Procedures. Direct, hands-on clinical education experience will begin within PT 572 Clinical Education II.

**PT 502 Therapeutic Exercise II - James Dexter, Burke Gurney, Kathy Dieruf, Maria Shea**

This course presents principles of management of patients using orthotic and/or prosthetic devices. Principles and applications of aquatic therapy, as well as evaluation and treatment of patients with cardiopulmonary diagnosis are also covered. Prerequisites: PT 501, 541, 570. Corequisite: PT 572. PT 502 serves as a prerequisite for: PT 601, 661, 671, 602, 672 and 675.

**PT 506 Therapeutic Procedures - Burke Gurney**

This course presents the study of theory, physiological effects and clinical applications of thermal and cryo agents, electrical currents and hydrotherapy. Electromyography related to neuromuscular function and biofeedback is also covered, as well as, principles and techniques of spinal traction. The emphasis of the course is on appropriate selection of and physiological responses to these techniques and the motor skill required for accurate and safe clinical application. Prerequisites: PT 521, PT 570, PT 541, and PT 530. Corequisites: PT 522, 552 and 572. PT 506 serves as a prerequisite for PT 601, 671, 672, 675 and 695.

### **PT 522 Neuroanatomy - Heather Murray**

This course involves detailed study of the anatomy the human nervous system. Neuroanatomical knowledge is necessary for understanding and treating all patients, especially neurologically involved patients. Prerequisite: PT 521. Corequisite: PT 506 and 552. PT 522 serves as a prerequisite for PT 641, 601, 602 and 661.

### **PT 542 Survey of Medical Sciences II: Orthopaedic Pathology - Zina Geller**

The purpose of this course is to familiarize the student with common orthopaedic pathological and pathokinesiological conditions, key signs and symptoms associated with these conditions, their surgical management, and implications for rehabilitation. Through lectures on orthopedic pathologies that are most commonly seen for rehabilitation by physical and occupational therapists, the student will develop an understanding of common orthopaedic conditions and their medical management. Surgical management of orthopaedic conditions is a key focus of this course. Students will be expected to integrate information from current literature and reference texts with information presented by guest speakers. Prerequisites: PT 521 L, 541 and 570L. Corequisites: PT 552L and 572L. This course serves as a prerequisite for: PT 671 L, 672L, 675L and 695.

### **PT 552 Evaluative Procedures I - Ron Andrews**

The purpose of this course is to enable the student to conduct a patient interview and utilize specialized techniques to evaluate a patient. The student is then expected to determine the underlying neuromusculoskeletal basis for dysfunction and presenting complaints as well as perform a basic screening for disease. The results of the evaluation are then analyzed and prioritized to determine appropriate treatment regimens and/or to determine if management of the patient lies within the scope of physical therapy. Referral guidelines are addressed. Prerequisites: PT 501 L, 521 L, 541, 570L and 551 L. Corequisites: PT 506L, 522L, 542 and 572L. This course acts as a prerequisite for PT 601L, 6L71, 672L, 675L and 695L.

### **PT 572L\*Clinical Education II - Zina Geller**

The primary purposes of this course are to introduce the student to the clinical situation and the patient--therapist relationship, to allow the student to gain experience in direct patient care, to integrate academic course work in a clinical setting, and to provide an opportunity to practice clinical skills under supervision. This course includes two blocks of supervised clinical experience in the same facility totaling 3 full-time weeks or 120 hours. Rotations will involve direct experience in patient care in a local clinic, with a focus on outpatient orthopaedics. Integration of fall semester first year course work will be emphasized in the first clinical block that precedes spring course work. Integration of spring semester course work, particularly orthopaedic evaluation, will be emphasized in the second clinical block which follows spring semester course work. Prerequisite: PT 501L, 571L. Corequisites: PT 502L, 506L, 542 and 552L. This course acts as a prerequisite for PT 622, 671L, 672L and 675L.

### **Second Fall Semester**

During the second fall semester you will continue your science foundation with PT 641 Survey of Medical Sciences III - Neurology, and your professional course work will include: Health Sciences 600 Development

Through the Life Span, PT 601 Therapeutic Exercise III, PT 661 Evaluative Procedures II - Pediatrics and PT 695 Topics in Physical Therapy. PT 699 Independent Study is available for elective course work or research in an area of your choice and can be used for senior project credit. Clinical education experiences continue with PT 671 Clinical Education IV.

### **PT 600 Development Through the Life Span**

The purpose of this course is to enhance the students understanding about how individuals change across the life span. The focus will include differences in cognitive, biological and psychological functioning at all different stages of life. Prerequisites for this course are: PT 521 Human Anatomy, PT 522 Neuroanatomy, PT 552 Evaluative Procedures 1, and PT 570L Kinesiology

### **PT 601 Therapeutic Exercise III - Kathy Dieruf**

The purpose of PT 601, Therapeutic Exercise III, is to enhance the student's ability to use neurophysiological and developmental approaches for evaluation and treatment of patients with neuromuscular and musculoskeletal dysfunction. Prerequisites include: PT 501 and 502, Therapeutic Exercise I and II; PT 522 Neuroanatomy, PT 551, Human Physiology, PT 552, Evaluative Procedures I, & PT 570, Kinesiology; a corequisite is PT 641: Survey of Medical Sciences III - Neurology

### **PT 631 Research Practicum- Andrea Vierra, and PT faculty**

The purpose of this course is to enhance the student's knowledge of the research process, and prepare them to submit a research proposal and write the first 3 chapters (introduction, literature review and methods) for their independent study. Prerequisites: PT 530 Introduction to Research

### **PT 641 Survey of Medical Sciences III: Neurology - Kathy Dieruf**

The purpose of PT 641, Survey of Medical Sciences III: Neurology is to enhance student's knowledge of various neurologic diseases and problems, and to explore the relationship of physical therapy/occupational therapy to these neurological problems. The information presented in this course is vital for the physical therapist/occupational therapist in order to understand and work effectively with the neurologically involved patient, and builds on the knowledge obtained in the prerequisite for this course is PT 522, Neuroanatomy. For the physical therapy students, this course is a corequisite and a prerequisite of PT 601 and PT 602, Therapeutic Exercise III and IV. For the occupational therapy students, this course is a corequisite for Occ Th 610.

### **PT 661 Evaluative Procedures II - (Temporary Part-time Faculty)**

The purpose of PT 661, Evaluative Procedures II, is to enhance the student's ability to use neurophysiological and developmental approaches for evaluation and treatment of pediatric and adult patients with neuromuscular dysfunction. The course consists of Pediatric Evaluation and Treatment, which includes

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normal and abnormal development, and presents aspects of neurodevelopmental, sensorimotor, and sensory integrative approaches to treatment. Prerequisites: PT 501, 502, 522. Corequisite: PT 601, 641 and 671. PT 661 serves as a prerequisite for PT 672 and 675.

### **PT 671 L Clinical Education III and Seminar - Zina Geller**

One purpose of this course is to allow the student to continue to gain experience in direct patient care: to integrate academic course work in a clinical setting, and to provide an opportunity to practice clinical skills under supervision. The purpose of the clinical education seminars is to create skill in the development of treatment plans based upon the identification of movement dysfunctions and problem lists, focusing on orthopaedic patient management. The seminars are also intended to allow the student to integrate clinical experience with didactic knowledge, and to foster discussion, independent inquiry and problem solving in relation to patient cases. Each student will complete a two-week full-time block of clinical experience at an affiliated clinical facility under the supervision of a clinical instructor. Specific objectives, which are appropriate to each type of clinical setting, will be provided to guide and focus the learning experience. Clinical education seminars will be centered around discussion of cases primarily in orthopaedic evaluation and treatment, this course is intended to assist the student in integrating the philosophies and techniques of patient treatment using principles of anatomy, kinesiology, and the morphology and mechanical behavior of tissues. These principles are applied to specialized techniques with the goal to restore normal movement patterns and function. The emphasis is on identifying dysfunctions and problems from the history and examination, delineating treatment goals based upon those findings, and developing an initial treatment plan. The student will demonstrate proficiency in writing goals, developing treatment plans and performing treatment techniques. Prerequisites: PT 571 L and 572L. Corequisites: PT 601 L and 661 L. This course acts as a prerequisite for PT 622, 672L and 675L.

### **PT 695 Topics in Physical Therapy - Ron Andrews**

The purpose of this course is to offer the third year Physical Therapy student the opportunity to pursue an in depth study of specialty components of physical therapy practice. The student will work with both a faculty member as well as professionals in the clinical community who demonstrate excellence in that component. Prerequisites: Entire prior curriculum

#### Sections:

001: sports medicine

002: hand therapy 003: manual therapy 004:

neurologic therapy

005: critical care/cardiopulmonary therapy 006: adaptive equipment

007: professional publication 008: clinical program development

009: other

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**Second Spring Semester**

During the second spring semester, you will continue your science foundation with PT 642 Survey of Medical Sciences IV, and PT 622 Psychology of Disability. Professional course work continues with PT 602 Therapeutic Exercise IV and PT 680 Administration and Supervision. PT 599 is utilized for senior project activities. Clinical education experiences continue with PT 672 Clinical Education IV.

**PT 602 Therapeutic Exercise IV - Kathy Dieruf**

The purpose of PT 602 Therapeutic Exercise IV is to enhance the students knowledge of physical therapy evaluation, goal setting and treatments related to specific patient populations. Diagnoses include patients following burns, spinal cord injury, and with a variety of women's health issues. Also included are sections on hand therapy and pharmacology. Students are expected to incorporate previously learned skills with new information to perform timely, appropriate, and complete evaluations and treatment plans with the patient examples used. Prerequisites for this course include PT 541 and 641 (Survey of Medical Sciences I and III), and PT 522 (Neuroanatomy). This course is a prerequisite for PT 675 (Clinical Education V).

**PT 622 Psychology of Disability Jane Merrill, M.S., P.T.**

The purpose of PT 622, Psychology of Disability, is to enhance the students' awareness of psychological issues of the health professional and the patient, necessary to provide optimal care to patients. The course covers four areas: psychological issues for the health professional, including communication skills; general psychological issues for the patient; specific psychological issues for the patient because of age, culture or sexuality; and psychological issues for the patient with a specific disability. Prerequisites: PT 510, 571, 572 and 671. Corequisite: 672. PT 622 serves as a prerequisite for PT 675.

**PT 672L Clinical Education IV and Seminar - Zina Geller**

Two two-week full-time clinical education blocks (totaling 160 clinical hours) will involve direct experience in patient care in local clinics. These blocks may be in the areas of adult neurological rehabilitation, pediatric rehabilitation and/or acute care. In clinical assignments, the student will continue to gain experience with direct patient care, to address professional behavior in interpersonal and communication skills, and to display safety consciousness in the clinical setting. Specific objectives appropriate to each type of clinical setting will be distributed to students and clinical instructors to guide and focus the clinical learning experience. Greater emphasis is placed on independence in patient evaluation, treatment planning, and problem solving, as well as treatment implementation. Clinical education seminars will be held in a small group problem-based learning format centered on discussion of patient cases. Patient problem cases will include adult and pediatric neurological and orthopaedic dysfunction, acute care, women's health issues, and patients with multiple diagnoses. The course will be supplemented with lectures and labs associated with treatment issues that arise from the patient cases. This course is intended to help the student investigate and practice the philosophies and techniques of patient treatment using principles of anatomy, kinesiology, and the morphology and mechanical behavior of tissues, and to develop skill in treatment planning, treatment progression and treatment techniques. The emphasis is on delineating treatment plans based upon key dysfunctions and problem lists and developing cognitive and motor proficiency in learning and executing treatment techniques. The student will be able to develop a basic treatment plan, progress

treatment with awareness of the discharge plan, and perform treatment techniques appropriate to the treatment plan and goals. Prerequisites: PT 501 L, 506L, 542, 551 L, 552L, 571 L, 572L, and 671 L. Corequisites: PT 602L, 622. This course acts as a prerequisite for PT 675L.

### **PT 680 Organization and Administration - Terry Crowe (OT Faculty)**

The purpose of this course is to assist physical therapy students to effectively practice in an increasingly complex health care delivery system. The course will provide a basic understanding of organizational systems including program planning and development, management and reimbursement. Prerequisites: PT 510, 571, 572 and 671. Corequisite: PT 672. PT 680 serves as a prerequisite for PT 675.

### **PT 599 Master's Thesis - Kathy Dieruf (coordinator)**

PT 599 is an independent study that also serves as the course of record for the Master's research [thesis](#). PT 599 is designed to provide a research experience to foster in the student the ability to use outside sources to answer relevant questions and become an effective problem-solver. The purpose of the Master's thesis is to enable the student to explore a physical therapy related topic in greater depth than is possible in the basic curriculum, and to obtain knowledge and expertise in an area beyond the level of the new graduate. The Master's thesis is designed to- introduce the student to research, and to enable the student to experience decision-making, use of the library, and creative thinking. The specific pre-requisites for this course are PT 530, Introduction to Research and PT 631, Research Practicum.

### **PT 675 Clinical Education V - Zina Geller**

Students will complete three full-time eight-week clinical rotations. The first rotation is scheduled during June and July of the second year curriculum; the second and third rotations are scheduled during the spring semester of the final year of the curriculum. Each rotation is expected to consist of approximately 40 hours per week, but exact hours, schedule and dates of participation may vary with the facility. Full-time clinical assignments are made in the areas of general acute care, neurological rehabilitation, orthopaedic, geriatric or pediatric facility, or specialty hospital or program. This course is intended to provide the student with an opportunity to participate in a patient care program that involves evaluation, initiation and modification of a treatment plan, discharge procedures, independent scheduling of patients, coordination of patient care activities with other health care professionals and supervision of supportive personnel. Students are expected to maintain an independent patient load, under supervision of a clinical instructor, and to achieve entry-level performance in each area at the completion of each full-time affiliation. Prerequisites: didactic portion of the 1st and 2<sup>nd</sup> year curriculum and PT 571 L, 572L, 671 L and 672L.



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# Course Descriptions

Department of Orthopedics  
Physical Therapy Program

## Physical Therapy (Phi Th.)

**501L. Therapeutic Exercise I. (3)** This course includes information on basic transfers, gait training and general therapeutic exercise techniques. Basic evaluation techniques such as manual muscle testing and goniometric measurements are also included. A component of this course also deals with soft tissue assessment and treatment techniques, including Western massage techniques and soft tissue mobilization. Course material includes the purposes, indications, contraindications, and physiological effects of each type of treatment. An effort is made to apply learning to clinical problems. Prerequisites: 521 L, 570L. Corequisite: 541. Taught by: Burke Gurney, M.A., P.T. and Zina Geller, MOMT, PT

**502L. Therapeutic Exercise II. (3)** This course presents principles of management of patients using orthotic and/or prosthetic devices. Principles and applications of aquatic therapy, as well as evaluation and treatment of patients with cardiopulmonary diagnosis are also covered. Prerequisites: PT 501, 541, 570. Corequisite: PT 572. PT 502 serves as a prerequisite for: PT 601, 661, 671, 602, 672 and 675. Taught by: Burke Gurney, M.A., P.T. James Dexter, P.T., Kathy Dieruf, Ph.D., P.T.

**506L. Therapeutic Procedures. (3)** This course presents the study of theory, physiological effects and clinical applications of thermal and cryo agents, electrical currents, and hydrotherapy. Electromyography related to neuromuscular function and biofeedback is also covered, as well as, principles and techniques of spinal traction. The emphasis of the course is on appropriate selection of and physiological responses to these techniques and

the motor skill required for accurate and safe clinical application. Prerequisites: PT 521, PT 570, PT 541, and PT 530. Corequisites: PT 522, 552, and 572. PT 506 serves as a prerequisite for PT 601, 671, 672, 675 and 695.

**510. Introduction to Physical Therapy. (2)** The purpose of PT 510 is to introduce students to the profession of physical therapy. The course includes a description of the history and development of physical therapy as a profession including the professional organization; a review of ethical and legal aspects; and methods of assuring that the profession is meeting the needs of the public. The course also introduces basic educational concepts and learning styles, including determining one's own style, as well as information on verbal and non-verbal communication. The course is a prerequisite for PT 571, 671, 622 and 680. Prerequisite: 521 L. Taught by: Burke Gurney, M.S., P.T.

**521 L. (H Sci 521 L.) Human Anatomy. (6)** (Also offered as Occ Th 521 L.) PT 521 is an intensive study of the structures of the human body; the information presented is fundamental to nearly all aspects of the practice of physical therapy. The primary emphasis is the study of the macroscopic structure of the musculoskeletal, cardiovascular and pulmonary systems; detailed anatomy of the brain and spinal cord will be studied in PT 522 Neuroanatomy. The following areas also will be studied in this course: histology of basic tissues, the gastrointestinal system, the integumentary system, the genitourinary system, and the male and female reproductive system. The course serves as a prerequisite for all future basic sciences and professional course work, especially PT 570 Kinesiology, and PT 552 Evaluative Procedures. Prerequisites for this course are 8 semester hours of human biology, 8 semester hours of anatomy and physiology, 4 semester hours of microbiology, 8 semester hours of physics, 8 semester hours of general chemistry and 4 hours of organic or biochemistry. Prerequisite: admission to program. Taught by: Heather Murray, Ph.D., P.T.

**522L. (522) Neuroanatomy. (3)** (Also offered as Occ Th 522L.) This course involves detailed study of the anatomy the human nervous system. Neuroanatomical knowledge is necessary for understanding and treating all patients, especially neurologically involved patients. Prerequisite: PT 521. Corequisite: PT 506 and 552. PT 522 serves as a prerequisite for PT 641, 601, 602 and 661. Taught by: Heather Murray, Ph.D., P.T.

**530. Introduction to Research. (2)** (Also offered as Occ Th 530.) The purpose of this course is to assist physical therapy students to grasp the basic concepts of research (reliability, validity, differences in research designs), to be able to critique and utilize the professional literature at a beginning level of competence, to gain a sense of the process of scientific inquiry, and to develop basic skills in writing in a scientific format. Students are expected to have a basic understanding of statistics before entering the course. It is expected that at the end of the course, students will be prepared to be competent consumers of research. That is, when reading research, the student will be able to critically assess the questions being posed and determine their significance, analyze the appropriateness, strengths and limitations of the methods being used, understand the significance of the data, decipher whether the conclusions are consistent with the results, identify remaining unanswered questions and relate the relevance of the research results to clinical problems. This course essentially serves as a prerequisite for all of the professional courses in that the student is expected to critically review literature during the curriculum as well as throughout their professional [careers](#). PT 530 specifically serves as the foundation for development and completion of the senior research project (PT 631 and 699).

**541. Survey of Medical Sciences for Physical Therapists I. (2)** (Also offered as Occ Th 541.) Pathology is the study of disease and disease processes. The goal of this course is to provide the student with a clear picture of the pathophysiology and clinical presentation of common disease entities. The emphasis is on disease

processes that are most likely to have manifestations requiring physical therapy intervention. These diseases include: neoplastic, cardiac, pulmonary, musculoskeletal, vascular, renal, infectious, immunological, hematological, and metabolic disorders. Trauma, shock, epidemiology, and specific infectious organism schema such as HIV are also [covered](#). PT 521. Corequisites: PT 570, 571, and 551. PT 541 serves as a prerequisite for: PT 502, 506, 542, 552, 572, 601, 671, 602, 672 and 695.

**542. Survey of Medical Sciences II and Seminar. (3)** (Also offered as Occ Th 542.) The purpose of this course is to familiarize the student with common orthopaedic pathological and pathokinesiological conditions, key signs and symptoms associated with these conditions, their surgical management, and implications for rehabilitation. Through lectures on orthopedic pathologies that are most commonly seen for rehabilitation by physical and occupational therapists, the student will develop an understanding of common orthopaedic conditions and their medical management. Surgical management of orthopaedic conditions is a key focus of this course. Students will be expected to integrate information from current literature and reference texts with information presented by guest speakers. Prerequisites: PT 521 L, 541 and 570L. Corequisites: PT 552L and 572L. This course serves as a prerequisite for: PT 671 L, 672L, 675L and 695. Taught by: Zina Geller, M.O.M.T., P.T.

**551. Clinical Exercise Physiology. (3)** This course includes principles of exercise physiology as they relate to the various systems of the body, including how pathological conditions affect these systems. There is an emphasis on acute and chronic effects of exercise on the various systems of the body with exercise evaluation and designing specialized exercise programs for effective patient care. It builds on the fundamental organization introduced in basic human physiology, a prerequisite for this program. Prerequisites: 8 semester hours of basic anatomy and physiology and PT 521. Corequisites: PT 501, 541 and 570. PT 551 serves as a prerequisite for PT 502, 552, 572, 601, 402, 671, 672, 695 and 675. Taught by: Burke Gurney, M.A, P.T.

**552L. Evaluative Procedures I. (3)** The purpose of this course is to enable the student to conduct a patient interview and utilize specialized techniques to evaluate a patient. The student is then expected to determine the underlying neuromusculoskeletal basis for dysfunction and presenting complaints as well as perform a basic screening for disease. The results of the evaluation are then analyzed and prioritized to determine appropriate treatment regimens and/or to determine if management of the patient lies within the scope of physical therapy. Referral guidelines are addressed. Prerequisites: PT 501 L, 521 L, 541, 570L and 551 L. Corequisites: PT 506L, 522L, 542 and 572L. This course acts as a prerequisite for PT 601 L, 671 L, 672L, 675L and 695L. Taught by: Ron Andrews, M. S., P. T.

**570L. Kinesiology and Functional Anatomy. (3)** (Also offered as Occ Th 570L.) The purpose of this course is to familiarize the student with common orthopaedic pathological and pathokinesiological conditions, key signs and symptoms associated with these conditions, their surgical management, and implications for rehabilitation. Through lectures on orthopedic pathologies that are most commonly seen for rehabilitation by physical and occupational therapists, the student will develop an understanding of common orthopaedic conditions and their medical management. Surgical management of orthopaedic conditions is a key focus of this course. Students will be expected to integrate information from current literature and reference texts with information presented by guest speakers. Prerequisites: PT 521L, 541 and 570L. Corequisites: PT 552L and 572L. This course serves as a prerequisite for: PT 671 L, 672L, 675L and 695.

**571L. Clinical Education I. (2)** The focus of this course is on PT documentation and clinical communication skills. The student will study the SOAP note format and have opportunities to practice documentation using this format. The course will also address medical terminology using a programmed learning approach. Included also is information on reviewing medical records and a unit on Spanish for medical personnel. This course also includes a unit of problem-based learning intended to allow students to integrate knowledge and clinical skills from other courses, and to foster discussion, independent inquiry and problem solving in relation to patient cases. Ethical issues will be addressed by one lecture. Prerequisite: PT 521. Corequisite: PT 541. This course acts as a prerequisite for PT 572, 622, 671, 672 and 675. Taught by: James Dexter, P.T., Heather Murray, Ph.D., P.T. and Zina Geller, MOMT, P.T.

**572L. Clinical Education II. (1)** The primary purposes of this course are to introduce the student to the clinical situation and the patient--therapist relationship, to allow the student to gain experience in direct patient care, to integrate academic course work in a clinical setting, and to provide an opportunity to practice clinical skills under supervision. This course includes two blocks of supervised clinical *experience in the same facility totaling 3 full-time weeks or 120 hours. Rotations will involve direct experience in patient care in a local clinic, with a focus on outpatient orthopaedics.* Integration of fall semester first year course work will be emphasized in the first clinical block that precedes spring course work. Integration of spring semester course work, particularly orthopaedic evaluation, will be emphasized in the second clinical block which follows spring semester course work. Prerequisite: PT 501L, 571 L. Corequisites: PT 502L, 506L, 542 and 552L. This course acts as a prerequisite for PT 622, 671 L, 672L and 675L. Taught by: Zina Geller, MOMT, P.T.

**600. (H Sci 600.) (3) Development Across the Lifespan.** The purpose of this course is to enhance the student's understanding about how individuals change across the life span. The focus will include differences in cognitive, biological and psychological functioning at all different stages of life. Prerequisites for this course are: PT 521 Human Anatomy, PT 522 Neuroanatomy, PT 552 Evaluative Procedures 1, and PT 570L Kinesiology Taught by: Ron Andrews, M.S., P.T.

**601L. Therapeutic Exercise III. (4)** The purpose of PT 601, Therapeutic Exercise III, is to enhance the student's ability to use neurophysiological and developmental approaches for evaluation and treatment of patients with neuromuscular and musculoskeletal dysfunction. Prerequisites include: PT 501 and 502, Therapeutic Exercise I and II; PT 522 Neuroanatomy, PT 551, Human Physiology, PT 552, *Evaluative Procedures I, & PT 570, Kinesiology; a corequisite is PT 641: Survey of Medical Sciences III - Neurology.* Taught by: Kathy Dieruf, Ph.D., P.T.

**602L. Therapeutic Exercise IV. (3)** The purpose of PT 602 Therapeutic Exercise IV is to enhance the students knowledge of physical therapy evaluation, goal setting and treatments related to specific patient populations. Diagnoses include patients following burns, spinal cord injury, and with a variety of women's health issues. Also included are sections on hand therapy and pharmacology. Students are expected to incorporate previously learned skills with new information to perform timely, appropriate, and complete evaluations and treatment plans with the patient *examples used.* Prerequisites for this course include PT 541 and 641 (Survey of Medical Sciences I and III), and PT 522 (Neuroanatomy). This course is a prerequisite for PT 675 (Clinical Education V). Taught by: Kathy Dieruf, Ph.D., P.T.

**622. Psychology of Disability. (2)** The purpose of PT 622, Psychology of Disability, is to enhance the students' awareness of psychological issues of the health professional and the patient, necessary to provide optimal care to patients. The course covers four areas: psychological issues for the health professional, including

communication skills; general psychological issues for the patient; specific psychological issues for the patient because of age, culture or sexuality; and *psychological issues for the patient with a specific disability*.

*Prerequisites:* PT 510, 571, 572 and 671. *Corequisite:* 572. PT 622 serves as a prerequisite for PT 675.

**PT 631 Research Practicum. (2)** The purpose of this course is to enhance the student's knowledge of the research process, and prepare them to submit a *research proposal and write the first 3 chapters (introduction, literature review and methods)* for their independent study. *Prerequisites:* PT 530 Introduction to Research

**641. Survey of Medical Science for Physical Therapists III and Seminar. (3)** The purpose of PT 641, *Survey of Medical Sciences III: Neurology* is to enhance student's knowledge of various neurologic diseases and problems, and to explore the relationship of physical therapy/occupational therapy to these neurological problems. The information presented in this course is vital for the physical therapist/occupational therapist in order to understand and work effectively with the neurologically involved patient, and builds on the knowledge obtained in the prerequisite for this course is PT 522, Neuroanatomy. For the physical therapy students, this course is a corequisite and a prerequisite of PT 601 and PT 602, Therapeutic Exercise III and IV. For the occupational therapy students, this course is a corequisite for Occ Th 610. Taught by: Kathy Dieruf, Ph.D., P.T.

**662L. Evaluative Procedures II. (4)** The purpose of PT 661, Evaluative Procedures II, is to enhance the student's ability to use neurophysiological and developmental approaches for evaluation and treatment of pediatric and adult patients with neuromuscular dysfunction. The course consists of Pediatric Evaluation and Treatment, which includes normal and abnormal development, and presents aspects of neurodevelopmental, sensorimotor, and sensory integrative approaches to treatment. *Prerequisites:* PT 501, 502, 522. *Corequisite:* PT 601, 641 and 671. PT 661 serves as a prerequisite for PT 672 and 675.

**671L. Clinical Education III. (5)** One purpose of this course is to allow the student to continue to gain experience in direct patient care: to integrate academic course work in a clinical setting, and to provide an opportunity to practice clinical skills under supervision. The purpose of the clinical education seminars is to create skill in the development of treatment plans based upon the identification of movement dysfunctions and problem lists, focusing on orthopaedic patient management. The seminars are also intended to allow the student to integrate clinical experience with didactic knowledge, and to foster discussion, independent inquiry and problem solving in relation to patient cases. Each student will complete a two-week full-time block of clinical experience at an affiliated clinical facility under the supervision of a clinical instructor. Specific objectives, which are appropriate to each type of clinical setting, will be provided to guide and focus the learning experience. Clinical education seminars will be centered around discussion of cases primarily in orthopaedic evaluation and treatment, this course is intended to assist the student in integrating the philosophies and techniques of patient treatment using principles of anatomy, kinesiology, and the morphology and mechanical behavior of tissues. These principles are applied to specialized techniques with the goal to restore normal movement patterns and function. The emphasis is on identifying dysfunctions and problems from the history and examination, delineating treatment goals based upon those findings, and developing an initial treatment plan. The student will demonstrate proficiency in writing goals, developing treatment plans and performing treatment techniques. *Prerequisites:* PT 571 L and 572L. *Corequisites:* PT 601 L and 661 L. This course acts as a prerequisite for PT 622, 672L and 675L. Taught by: Zina Geller, MOMT, P.T.

**PT 695 Topics in Physical Therapy -(6)** The purpose of this course is to offer the third year Physical Therapy student the opportunity to pursue an in depth study of specialty components of physical therapy practice. The student will work with both a faculty member as well as professionals in the clinical community who

demonstrate excellence in that component. Prerequisites: Entire prior curriculum Sections: 001: sports medicine 002: hand therapy 003: manual therapy 004: neurologic therapy 005: critical care/cardiopulmonary therapy 006: adaptive equipment 007: professional publication 008: clinical program development 009: other

**672L. Clinical Education IV. (5)** Two two-week full-time clinical education blocks (totaling 160 clinical hours) will involve direct experience in patient care in local clinics. These blocks may be in the areas of adult neurological rehabilitation, pediatric rehabilitation and/or acute care. In clinical assignments, the student will continue to gain experience with direct patient care, to address professional behavior in interpersonal and communication skills, and to display safety consciousness in the clinical setting. Specific objectives appropriate to each type of clinical setting will be distributed to students and clinical instructors to guide and focus the clinical learning experience. Greater emphasis is placed on independence in patient evaluation, treatment planning, and problem solving, as well as treatment implementation. Clinical education seminars will be held in a small group problem-based learning format centered on discussion of patient cases. Patient problem cases will include adult and pediatric neurological and orthopaedic dysfunction, acute care, women=s health issues, and patients with multiple diagnoses. The course will be supplemented with lectures and labs associated with treatment issues that arise from the patient cases. This course is intended to help the student investigate and practice the philosophies and techniques of patient treatment using principles of anatomy, kinesiology, and the morphology and mechanical behavior of tissues, and to develop skill in treatment planning, treatment progression and treatment techniques. The emphasis is on delineating treatment plans based upon key dysfunctions and problem lists and developing cognitive and motor proficiency in learning and executing treatment techniques. The student will be able to develop a basic treatment plan, progress treatment with awareness of the discharge plan, and perform treatment techniques appropriate to the treatment plan and goals. Prerequisites: PT 501 L, 506L, 542, 551 L, 552L, 571 L, 572L, and 671 L. Corequisites: PT 602L, 622. This course acts as a prerequisite for PT 675L. Taught by: Zina Geller, MOMT, P.T.

**675L. Clinical Education V. (6)** Students will complete three full-time eight-week clinical rotations. The first rotation is scheduled during June and July of the second year curriculum; the second and third rotations are scheduled during the spring semester of the final year of the curriculum. Each rotation is expected to consist of approximately 40 hours per week, but exact hours, schedule and dates of participation may vary with the facility. Full-time clinical assignments are made in the areas of general acute care, neurological rehabilitation, orthopaedic, geriatric or pediatric facility, or specialty hospital or program. This course is intended to provide the student with an opportunity to participate in a patient care program that involves evaluation, initiation and modification of a treatment plan, discharge procedures, independent scheduling of patients, coordination of patient care activities with other health care professionals and supervision of supportive personnel. Students are expected to maintain an independent patient load, under supervision of a clinical instructor, and to achieve entry-level performance in each area at the completion of each full-time affiliation. Prerequisites: didactic portion of the 1<sup>st</sup> and 2<sup>nd</sup> year curriculum and PT 751 L, 572L, 671 L, and 672L. Taught by: Zina Geller, MOMT, P.T.

**680. Organization and Administration. (2)** (Also offered as Occ Th 680.)The purpose of this course is to assist physical therapy students to effectively practice in an increasingly complex health care delivery system. The course will provide a basic understanding of organizational systems including program planning and development, management and reimbursement. Prerequisites: PT 510, 571, 572 and 671. Corequisite: PT 672. PT 680 serves as a prerequisite for PT 675.

**599. Individual Study. (3)** PT 599 is an independent study which also serves as the course of record for the Master=s research [thesis. PT 599](#) is designed to provide a research experience to foster in the student the ability to use outside sources to answer relevant questions and become an effective problem-solver. The

purpose of the Master's thesis is to enable the student to explore a physical therapy related topic in greater depth than is possible in the basic curriculum, and to obtain knowledge and expertise in an area beyond the level of the new graduate. The Master=s thesis is designed to- introduce the student to research, and to enable the student to experience decision-making, use of the library, and creative thinking. The specific pre-requisites for this course are PT 530, Introduction to Research and PT 631, Research Practicum. Taught by: Kathy Dieruf, Ph.D., P.T.

To order a UNM Catalog please call The Office of the Registrar at (505) 277-5548 or write to them at: UNM Office of the Registrar, Student Services Center, Albuquerque, NM 87131-2039. They are also available at the UNM Bookstore.

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## University of Delaware

### Course Descriptions - Physical Therapy

**PHYT600-PT as a Profession: (1)**

An introduction to the ethics, licensure law and practice of physical therapy. Open to MPT Program students only. Requires permission of instructor.

**PHYT622-Clinical Gross Anatomy: (6)**

Emphasis on structural and functional aspects of regions of body under study by means of human cadaver, lectures and demonstrations. Stresses clinical significance of anatomical structure. Open to [first-yr. PT](#) graduate students only.

**PHYT801-Medical Science 1:(2)**

Lectures in pathology, clinical medicine, cardiology, and pharmacology. Open to MPT students only.

**PHYT601-Exercise Physiology: Treatment and Research:(3)**

Discusses research on the effects of exercise on various patient populations. Emphasis on muscle, bone and connective tissue remodeling. Examines cardiopulmonary rehabilitation, isokinetic and isotonic theories and research. Open to MPT students only.

**PHYT602-Patient Management 1:(3)**

An introduction to the theory and skills necessary for the PT management of patients commonly seen in primary care facilities. Open to MPT students only.

**PHYT603-Physical Agents:(2)**

Introduces the physics, physiology, and clinical applications of various physical agents. Incorporates this new knowledge into patient care. Open to MPT students only.

**PHYT624-Introduction to Evaluation Techniques:(I)**

Provides the student with an understanding of the philosophy and practice of patient evaluation and p.t. diagnosis. Muscle performance testing and measurement of joint motion of the extremities will be emphasized. Open to MPT students only.

**PHYT606-Research Methods:(3)**

The research process will be studied. Among the topics covered are scientific method, experimental design, statistical procedures and technical writing. Open to MPT students only.

**PHYT605-Clinical Internship:(1-9)**

Full or part-time clinical experiences at various health care facilities. Open to MPT students only with completion of prior professional course work.

**PHYT604-Functional Anatomy:(3)**

Gives a description of normal and abnormal human movement. Emphasis on surface anatomy and evaluation procedures such as EMG.PREREQ:BISC401 and PHYT622.

**PHYT623-Clinical Neuroscience:(4)**

A study of the structure and function of the human nervous system with major emphasis on the cause-effect relationships between lesions and their symptoms. Emphasis on the neural mechanisms controlling movement. PREREQ:PHYT622

**PHYT607-Electrophysiological Treatment and Evaluation:(3)**

Emphasis on the physiological basis for the electrotherapeutic and electrophysiological evaluative procedures practiced in the PT clinic. Open to MPT students only.

**PHYT620-Educational process in Community Health:(1)**

Focuses on the learning/teaching process for application to the teaching roles of the health professional. Open to MPT students only.

**PHYT608-Musculoskeletal Evaluation:(3)**

In depth analysis of evaluation and treatment strategies of spinal and extremity joints, muscles and connective tissue. Emphasizes research on the physiological basis of traction, mobilization and exercise.

**PHYT802-Medical Science 11(2)**

Lectures in orthopedics, radiology and rheumatology. PREREQ: all previous MPT courses.

**PHYT609-Neurophysiologic Evaluation:(3)**

In depth analysis of evaluation and treatment strategies of neurologically involved patients. Emphasizes research on the physiological basis of traction, mobilization and exercise. PREREQ: All previous MPT courses.

**PHYT611-Clinical Management Practices:(1)**

Discusses concepts of administration and issues in the management of hospital clinics, private practice and consultative ventures. PREREQ: All first year MPT courses.

**PHYT617-Patient Management:(3)**

Continuation of PHYT602. Teaches the theory and skills necessary for the physical therapy management of patients commonly seen in rehabilitation settings. PREREQ:PHYT602. Open to MPT students only.

**PHYT618-Life Span Development:(3)**

A study of human development and aging from birth through death. Emphasis on motor, sensory and cognitive functions and dysfunction. PREREQ: all first year MPT courses.

**PHYT803-Medical Science III:(2)**

Lectures in neurology, pediatrics, geriatrics and other medical specialties as required. PREREQ: All previous MPT courses.

**PHYT610-Psychosocial aspects of disabilities:(2)**

Discusses the psychosocial characteristics of patient populations and therapists that impact on the rehabilitative process. Time management, death and dying, sexuality, love and hate and other topics are discussed. PREREQ: All previous MPT courses.

**PHYT619-Advanced Seminar:(2)**

Lectures pursue various topics in greater depth and develop advanced clinical skills. Examples include burn and wound care, hand therapy, and geriatrics. Individualized clinical experiences may be arranged. PREREQ: All previous MPT courses.

**PHYT621-Practice Clinic: (1) *NOTE-MUST BE TAKEN AT LEAST ONCE DURING DEGREE PROGRAM***

Student participation in faculty practice clinic treating referrals for PT.

**ELECTIVES**

**PHYT612-Clinical Management Practicum:(3)**

Full or part-time practicum in a management setting. Advance skills in management.

**PHYT613-Advanced Orthopedics:(3)**

Discusses various schools of orthopedic intervention.

**PHYT614-Sport Physical Therapy:(3)**

Analyzes the various components required in the practice of sports physical therapy. Clinical skills acquired.

**PHYT615-Advanced Neurotherapeutics:(3)**

Discusses an integration of the various neurodevelopmental approaches to the treatment of the neurological patient.

**PHYT616-Pediatrics Seminar: (3)**

Discusses selected problems encountered by the pediatric population. Studies the evaluation, treatment and research basis of these problems

**PHYT626-Advanced Regional Anatomy: (3)**

Structural and functional aspects of regions of the body under study are emphasized by means of a dissection of a specific region of the human body. PREREQ: PHYT622

**\*\*\*Curriculum is subject to modification as program is implemented.**

301 McKinly Lab University of Delaware Newark, DE 19716 phone 302-831-8910 fax 302-831 -1234  
Comments to: [staciec@udel.edu](mailto:staciec@udel.edu)  
last edited: 6/2000

<http://www.udel.edu/PT/pros-students/courses.html>

10/12/00



## Program Curriculum

The professional physical therapy curriculum leads to a Bachelor of Science degree in Health Science and a Master of Physical Therapy and is seven semesters in length, including a summer session between the second and third years.

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### PROFESSIONAL CURRICULUM IN PHYSICAL THERAPY Fall

#### Semester, Year One

- BIOS 355 Human Physiology(4)
- BIOS 446 Gross Human Anatomy (6)
- AHPT 400 Introduction to Physical Therapy (1)
- AHPT 402 Health Care Systems (2)
- AHPT 410 Physical Therapy Science I - Assessment (4)
- AHPT 460 Clinical Experience 1(1)

#### Spring Semester, Year One

- AHPT 403 Communication and Patient Education (2)
- AHPT 404 Case Studies in Physical Therapy 1(1)
- AHPT 411 Physical Therapy Science II - Therapeutic Modalities (4)
- AHPT 413 Musculoskeletal Basis of Human Movement (2)
- AHPT 440 Evaluation and Treatment of Musculoskeletal Disorders Extremities (4)
- AHPT 442 Medical Management of Musculoskeletal Disorders (3)
- AHPT 461 Clinical Experience 11(1)

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**Fall Semester, Year Two**

- AHPT 409 Physical Therapy Research 1(2)
- AHPT 412 Physical Therapy Science III - Electrotherapy (2)
- AHPT 415 Neurological Basis of Human Movement (4)
- AHPT 417 Pathology and Pharmacology for Physical Therapists (3)
- AHPT 450 Physical Therapy Administration (3)
- AHPT 462 Clinical Experience 111(4)

**Spring Semester, Year Two**

- AHPT 425 Motor Development for Physical Therapists (3)
- AHPT 436 Acute Care for Physical Therapists (3)
- AHPT 437 Cardiopulmonary Physical Therapy (3)
- AHPT 503 Psychosocial Issues for Physical Therapists (2)
- AHPT 504 Case Studies for Physical Therapists 11(1)
- AHPT 540 Evaluation and Treatment of Musculoskeletal Disorders - Spine (3)

**Summer Semester, Year Two**

- AHPT 560 Clinical Experience IV (4)

**Fall Semester, Year Three**

- AHPT 505 Case Studies in Physical Therapy III (2)
- AHPT 509 Physical Therapy Research 11(3)
- AHPT 545 Independent Study (1 - 3)
- AHPT 550 Neurological Physical Therapy (4)
- AHPT 551 Medical Issues in Neurological Physical Therapy (2)
- AHPT 555 Rehabilitation in Physical Therapy (4)

**Spring Semester, Year Three**

- AHPT 561 Clinical Experience V (12)
- AHPT 570 Physical Therapy Seminar (2)

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10/12/00

**TAB THREE**

## **ADVOCACY MATERIALS**

- I. Sample Talking Points on Direct Access *American Association of Orthopaedic Surgeons*
- II. Position Statement on Direct Access to Physical Therapists *Georgia Orthopaedic Society*
- III. Fact Sheet on Direct Access *Georgia Orthopaedic Society*
- IV. Sample Letter to Legislators on Direct Access Legislation *Georgia Orthopaedic Society*
- V. Letter to Orthopaedic Surgeons on Direct Access Legislation *Missouri State Orthopaedics Association*
- VI. Sample Letters to Legislators on Direct Access Legislation *Missouri State Orthopaedics Association*
- VII. Testimony of Arnold Berman, MD before the Pennsylvania House Committee on Professional Affairs  
*Pennsylvania Orthopaedic Society*



## **Sample Talking Points on Physical Therapists Requesting Direct Access**

- 1) Physical therapists claim that direct access will not expand their scope of practice since they may not make medical diagnoses, but only provide physical therapy treatment. This is disingenuous. When a patient presents to a physical therapist without a diagnosis the physical therapist must diagnose the patient to decide what the problem actually is, it may not be treatable by physical therapy, and what methods should be used to treat the patient. The physical therapist must therefore make a medical diagnosis.
- 2) Physical therapists are educated to provide physical therapy treatment for conditions, while medical doctors have a more extensive and broader education and training. Medical doctors have been trained in taking x-rays and in recognizing the physical symptoms of such conditions as renal failure or lung disease that may not be picked up by the physical therapist under direct access to the detriment of the patient.

Physicians are trained to make these medical diagnoses while Physical Therapists are not.

- 3) Direct access provides a financial incentive for the physical therapist to provide more care than is medically necessary. The medical doctor has no financial incentive to increase the amount of care provided by the physical therapist. The study relied upon by the physical therapists to prove that direct access care was shorter and less costly than physician referred care used a methodology so imprecise that no valid conclusions should be drawn from it. The study could not satisfactorily even determine which patients analyzed had been referred for treatment by a medical doctor.

With direct access there is not the same level of financial oversight and in many cases the initial evaluation is more expensive than an initial physician visit.

- 4) Physical therapists are an important part of the health care team that provides the best treatment in the world. Direct access, though, requires physical therapists to perform medical diagnosis that should only be done by more highly trained members of the health care team.

The issue of direct access also raises question about the ability of the physical therapy board to oversee physical therapists who are making medical diagnoses under direct access.

Economically and for patient safety the public is best served by requiring a physician referral before physical therapy is undertaken.

## Sample Talking Points on Physical Therapists Requesting Direct Access

- 5) Physical therapists claim that direct access will not expand their scope of practice since they may not make medical diagnoses, but only provide physical therapy treatment. This is disingenuous. When a patient presents to a physical therapist without a diagnosis the physical therapist must diagnose the patient to decide what the problem actually is, it may not be treatable by physical therapy, and what methods should be used to treat the patient. The physical therapist must therefore make a medical diagnosis.
- 6) Physical therapists are educated to provide physical therapy treatment for conditions, while medical doctors have a more extensive and broader education and training. Medical doctors have been trained in taking x-rays and in recognizing the physical symptoms of such conditions as renal failure or lung disease that may not be picked up by the physical therapist under direct access to the detriment of the patient.

Physicians are trained to make these medical diagnoses while Physical Therapists are not.

- 7) Direct access provides a financial incentive for the physical therapist to provide more care than is medically necessary. The medical doctor has no financial incentive to increase the amount of care provided by the physical therapist. The study relied upon by the physical therapists to prove that direct access care was shorter and less costly than physician referred care used a methodology so imprecise that no valid conclusions should be drawn from it. The study could not satisfactorily even determine which patients analyzed had had been referred for treatment by a medical doctor.

With direct access there is not the same level of financial oversight and in many cases the initial evaluation is more expensive than an initial physician visit.

- 8) Physical therapists are an important part of the health care team that provides the best treatment in the world. Direct access, though, requires physical therapists to perform medical diagnosis that should only be done by more highly trained members of the health care team.

The issue of direct access also raises question about the ability of the physical therapy board to oversee physical therapists who are making medical diagnoses under direct access.

Economically and for patient safety the public is best served by requiring a physician referral before physical therapy is undertaken.

## GEORGIA ORTHOPAEDIC SURGEON ASSOCIATION

### Position on Direct Access by Physical Therapists

The Georgia Orthopaedic Surgeon Association and its members strongly oppose SB 25. SB 25 would lower the standard of health care and jeopardize the health of Georgia citizens by giving independent practice authority to physical therapists.

Physical therapists are educated and trained to treat certain conditions of the musculoskeletal system with exercise. They are not trained to diagnose the basis for a problem. There is certainly the potential for harm to patients if a diagnosis is not made prior to treatment.

SB 25 is bad for the consumer because:

- The **educational program** for physical therapists in most cases consists of a mere two years of training. One of those years is spent in the classroom and an additional six months to a year is spent in a clinical apprenticeship. Nowhere in their educational program is there any significant amount of education in regard to diagnosis of medical conditions - orthopaedic and non-orthopaedic conditions, which commonly represent potential indications for physical therapy. However, there are many other conditions that the physician understands through his 8+ years of training and background, which represent contradictions, where patients should not be sent for physical therapy. The patient may have other conditions that require other kinds of treatment for common disorders such as back pain caused by a kidney tumor.
- Physical therapists reap enormous **financial rewards** for continuing physical therapy treatment. A physician has no economic interest in continuing physical therapy. There are no controls on the limits of treatment, when to begin, how to continue, when to stop. The physical therapist is essentially in a position where they have an inherent conflict of interest in regard to continuing the treatment. The cost of physical therapy treatment is likely to increase significantly.
- The physician bears a degree of **responsibility** when referring a patient to a physical therapist. Under SB 25, the physician stands to be put into a very difficult position of evaluating patients after treatment has been initiated with either no diagnosis or a mistaken diagnosis by the physical therapist.

There is a public danger of passing a bill that would enable physical therapists to treat patients without referrals from physicians and without a medically based diagnosis. Physical therapists are an integral part of the community health care system. In order for this system to function properly each member must function within his or her role. The current law defines the role of physical therapists based on the scope of their education and training, and it should not be expanded without regard to sound medical practices.

## GEORGIA ORTHOPAEDIC SOCIETY

- The educational program for physical therapists in most cases consists of a mere two years of training. One of those years is spent in the classroom and an additional six months to a year is spent in a clinical apprenticeship.
- Nowhere in their educational program is there any significant amount of education in regard to diagnosis of medical conditions - orthopaedic and non-orthopaedic conditions, which commonly represent potential indications for physical therapy.
- There are many other conditions that the physician understands through his 8+ years of training and background, which represent contradictions, where patients should not be sent for physical therapy. The patient may have other conditions that require other kinds of treatment for common disorders such as back pain caused by a kidney tumor.
- Physical therapists reap enormous financial rewards for continuing physical therapy treatment. A physician has no economic interest in continuing physical therapy.
- No controls on the limits of treatment, when to begin, how to continue, when to stop. The physical therapist is essentially in a position where they have an inherent conflict of interest in regard to continuing the treatment.
- The cost of physical therapy treatment is likely to increase significantly.
- The physician bears a degree of responsibility when referring a patient to a physical therapist.
- Physician's stands to be put into a very difficult position of evaluating patients after treatment has been initiated with either no diagnosis or a mistaken diagnosis by the physical therapist.

December 6, 1999

Honorable John Doe  
State Representative/Senator, District # State  
Capitol, Room 111 Atlanta, GA 30334

Dear Rep./Senator:

I write you today urging you to oppose any legislation that would grant physical therapists direct access to patients. Currently, there are two pieces of legislation pending that would give them this authority: SB 25, by Senator Nadine Thomas and HB 1045 by Rep. Sistie Hudson. SB 25 is in the Consumer Affairs Committee and HB 1045 is in the Health and Ecology Committee.

My opposition to this legislation begins with the fundamental concern that under direct access PT's would be able to see the patient without the benefit of a physician referral. The "team" approach that is in place today for treating diseases and conditions of the musculoskeletal system has functioned well for patients. The referral process is an integral part of that team approach. That is because it ensures that a proper diagnosis is made of the medical condition before the initiation of any treatment. My concern is that Physical Therapists do not have adequate training to make a medical diagnosis. This fear is exacerbated by the PT's lack of or ability to interpret diagnostic tools such as x-rays or laboratory tests. Such undertraining could lead to misdiagnosis or failure to diagnose conditions that may appear only to be musculoskeletal but could in fact be related to problems such as kidney infection, gynecological conditions or tumors. In addition, many of the problems of the musculoskeletal system are treatable with medication. Physical therapists are not trained in the use of medications in treating patients. By removing themselves from the "team", the PT's could be denying the patient access to the drugs they need.

Physical therapists play an important role in the delivery of care to their patients. However this care is best delivered based on a diagnosis and referral from a physician. This protects the patient and ensures that the right treatment is being given at the right time.

I appreciate the opportunity to share my concerns with you. Should you have any questions or need additional information, please let me know. Again, I urge you to oppose any direct access legislation.

Sincerely,

Dear Colleague,

February 16, 1998

This is a call to action on behalf of your profession and patients. The physical therapists of Missouri have enlisted the help of several lobbyists to enact legislation that would give physical therapists the legal authority to practice medicine. While the physical therapist is an important part of the treatment of patients, HB 1361 does not have the patients' best interest in mind.

The MSOA asks each of you to contact your state Representative and Senator to ask for their opposition on this bill. Please bring the following points in House Bill 1361 to his or her attention:

- HB 1361 relates to PT's referring patients for more advanced care if there is "reasonable cause to believe symptoms or conditions are present which require services beyond the scope of" the PT's practice. Physical therapists are not trained to make a medical diagnosis.
- HB 1361 would repeal current language that prohibits PT's from "treating or attempting to treat ailments or other health conditions of human beings other than by professional physical therapy. **HB 1361 allows a PT to practice medicine rather than physical therapy.**
- HB 1361 includes "debridement" as being in the practice of physical therapy. "Debridement" entails the surgical removal of dead or diseased tissue. Physical therapists are not surgeons or trained to perform surgery.
- PT's are not trained or qualified to take X-rays. Proper evaluation of musculoskeletal injuries often requires X-rays.
- Pain in a patient may be the result of a serious underlying cause not directly related to the musculoskeletal system. HB 1361 allows physical therapists to perform beyond their training.
- PT's are not trained or qualified to prescribe anti-inflammatory medications.
- HB 1361 does not require continuing education.

Physical Therapists are a valuable part of the health care team. However, successful teamwork requires well-defined roles of the members of this team. This bill will serve only to lower the standard of care, while driving up the cost of health care. A patient may be seen by a PT up to 12 times before being referred to a physician for further treatment. Imagine a patient with a fracture, waiting 12 weeks to have an X-ray because he or she went to a PT for diagnosis. Imagine a patient going to a PT for back pain. Is the PT qualified to diagnose that the pain is not caused by renal failure? Shoulder pain? Is it a torn ligament or lung disease?

Please call, write, or email your Legislators and ask them to vote against HB 1361. Use these points or any of your own. If this bill is passed, we cannot assure our patients proper care. You can access the content of this bill, and contact you state Representative and Senator through our web site, [www.msod.org](http://www.msod.org). Please see the January issue of Missouri Medicine; pages 40-43 will help you find your Representative. Call Jay Harms, MSOA staff at (573) 636-5151 for more information.

Sincerely,



Charles E. Rhoades, M.D.  
President  
Missouri State Orthopaedics Association

Dear Representative Donovan,

March 3, 1998

Some physical therapists in Missouri are pushing legislation that would give them the legal authority to practice medicine. While the physical therapy is an important part of the treatment of patients, HB 1361 does not have the patients' best interest in mind. The Missouri State Orthopaedic Association opposes this bill for the following reasons:

- HB 1361 would repeal current language that prohibits PT's from "treating or attempting to treat ailments or other health conditions of human beings other than by professional physical therapy." **HB 1361 allows a PT to practice medicine rather than physical therapy.**
- HB 1361 requires PT's to refer patients for more advanced care if there is "reasonable cause to believe symptoms or conditions are present which require services beyond the scope of the PT's practice. **Physical therapists are not trained to make these types of medical diagnoses.**
- PT's are not trained or qualified to take X-rays. **Proper evaluation of musculoskeletal injuries often requires X-rays.**
- Pain in a patient may be the result of a serious underlying cause not directly related to the musculoskeletal system. **Many conditions will have similar symptoms. Without proper diagnostic training these conditions may go untreated for 30 days under HB 1361.**
- **HB 1361 includes "debridement" as being in the practice of physical therapy. "Debridement" entails the surgical removal of dead or diseased tissue. Physical therapists are not surgeons or trained to perform surgery.**
- HB 1361 does not require continuing education.

Physical therapists are a valuable part of the health care team. However, successful teamwork requires well-defined roles of each member of the team. This bill will serve only to lower the standard of care, while driving up health care costs. A patient could be seen by a PT for up to 30 days before being referred to a physician for further treatment. Imagine a patient with a fracture, waiting 30 days to have an X-ray because he or she went to a PT for diagnosis. During the 30 days, the bone could grow back together incorrectly. In order to correct the fracture properly, the bone would have to be broken again by way of surgery, set, and splinted for a longer time than normally required.

Imagine a patient going to a PT for back pain. Is the PT qualified to diagnose that the pain is not caused by renal failure? Shoulder pain? Is it a torn ligament or lung disease? We cannot allow HB 1361 to lower the level of care Missourians receive.

The Missouri State Orthopaedic Association urges you to carefully consider the true impact of HB 1361. Physical therapists should practice therapy, not medicine.

Sincerely,



Charles E. Rhoades, M.D.  
President  
Missouri State Orthopaedics Association

Dear Representative (name),

March 12,1998

A substitute for House Bill 1361 which would allow physical therapists to practice without direction from a physician, was released last week. Though some of the semantics of the bill have changed, the reality of the bill is still to permit physical therapists to practice medicine. One provision in HB 1361 now reads:

"The practice of physical therapy does not include the determination of a medical diagnosis, use of surgery or obstetrics or the administration of radiation, radioactive substances, diagnostic x-ray, diagnostic laboratory electrocautery, electrosurgery, or invasive tests, or the prescribing of any drug, or the administration or dispensing of any drug or medicine other than a topical agent administered or dispensed upon the direction of a physician."

The intent of this bill is to allow physical therapists to legally practice medicine in Missouri. In the section quoted above, a physical therapist is not allowed to make a diagnosis, however, section 334.505, subsection 1, of the same bill says: "Nothing shall prevent a physical therapist from evaluating and treating a patient for thirty (30) days without a referral from a person licensed and registered as a physician and surgeon... whose license is in good standing." Proposed section 334.501 subsection 3 states "No candidate for licensure or person licensed as a physical therapist shall fail to refer a patient to an appropriate health care provider if symptoms are known to be present for which physical therapy is inadvisable, or if symptoms indicate conditions for which treatment is beyond the scope of physical therapy." In order to treat any condition by means of physical therapy, a diagnosis must be made, and this bill is allowing physical therapists to make that diagnosis.

The section above would exclude surgery as part of physical therapy. But, another provision in HB 1361 still contains language to allow "debridement." Webster's Ninth New Collegiate Dictionary defines debridement as "the surgical removal of lacerated, devitalized or contaminated tissue." Physicians from all over Missouri are taught in medical school that debridement is a surgical procedure. The scope of physical therapy should not include surgery.

Very little was changed when this substitute was rewritten. The words were changed, but the reality of what HB 1361 would allow physical therapists to do, remains the same. This bill will lower the level of care Missourians receive and will be economically senseless. This bill is economically motivated by the physical therapists to allow for 30 days of treatment without the appropriate supervision and diagnosis of a licensed physician. Not only, physicians, but insurance companies also, recognize the value of a correct diagnosis and treatment. Most insurance companies will not pay for physical therapy without a physician's prescription.

The physicians of the Missouri State Orthopaedic Association ask you to support Missouri's high level of patient care by voting against HB 1361.

Sincerely,



Charles E. Rhoades, M.D.

President

Missouri State Orthopaedics Association

**TESTIMONY BEFORE THE HOUSE COMMITTEE ON PROFESSIONAL AFFAIRS**

**ON BEHALF OF THE PENNSYLVANIA ORTHOPAEDIC SOCIETY**

**REGARDING PHYSICAL THERAPY LEGISLATION**

**Arnold T. Berman, M.D., President - Pennsylvania Orthopaedic Society**

**July 20, 1993**

**TESTIMONY BEFORE THE HOUSE COMMITTEE ON PROFESSIONAL AFFAIRS**

**ON BEHALF OF THE PENNSYLVANIA ORTHOPAEDIC SOCIETY**

**REGARDING PHYSICAL THERAPY LEGISLATION**

**Arnold T. Berman, M.D., President - Pennsylvania Orthopaedic Society Mr.**

Chairman, Members of the State Legislature, Ladies and Gentlemen:

It is my privilege to testify today as the President of the Pennsylvania Orthopaedic Society and as a practicing Orthopaedic Surgeon. Our organization represents the 750 practicing Orthopaedic Surgeons in Pennsylvania. There are approximately 15,000 practicing Orthopaedic Surgeons; and Pennsylvania represents the fourth largest group of Orthopaedic Surgeons in the U.S. By way of background, I am Professor & Chairman of the Department of Orthopaedic Surgery & Rehabilitation at Hahnemann University; and in this capacity, I bring to you a very unique perspective in that I am the founder of the largest and, I am told, the finest Physical Therapy School in Pennsylvania. As a result, I have first-hand knowledge of the educational process. Physical Therapy is a fine profession that now enjoys a collegial and cooperative relationship with all physicians. This relationship should continue. I, therefore, would like to discuss with you several compelling reasons why this Bill should not go forward and passed into

law. I would like to limit my comments to four (4) categories: 1) Education & Background; 2) Clinical Considerations, with special reference to clinical judgment and decision-making; 3) the gatekeeper concept and its effect on economics; and 4) the legal responsibility of the physician and other clinical practitioners. The bottom line is that Bill 1531 should not be considered because there is no way a physical therapist should ever treat a patient without having the patient seen by a physician who would first make the diagnosis and conduct an assessment of the patient. This Bill proposes that physical therapists may treat patients without a prior assessment from a doctor of medicine, osteopathy, dentistry or podiatry. It is not in the public interest to begin treatment without a diagnosis and physical therapists admittedly are not trained to make a diagnosis. Therefore, this Bill is clearly not in the public's interest. Quite frankly, it is scary.

Let's look at a couple real life situations:

The patient is treated by a Physical Therapist for "a sprained ankle". The Physical Therapist assumes the patient has a sprained ankle and treatment begins. The patient shows some difficulty with improvement and the treatment process becomes problematic. Ultimately the patient is referred to an Orthopaedic Surgeon, who x-rays the patient and finds that there is a fracture. At this point, it is difficult

to treat the fracture because too much time has elapsed. It required surgery from Day #1 of the injury; and now, four weeks later, the surgical procedure cannot achieve the optimal result and the patient remains disabled for life.

Let's take another common, real life situation. The patient is treated for back pain a Physical Therapist. Again, no diagnosis is made. Again, treatment proceeds without physician evaluation and referral. The patient does not improve. The assumption is made the patient has a muscular injury, a lumbar strain, or even a herniated disc; however, the patient shows no improvement. It is important to understand that there are many, many causes of back pain that must be diagnosed in advance of physical therapy treatment. For example, malignancies that spread to the spinal column; kidney tumors and other kidney disease commonly mimic as back pain; abdominal problems arising from the pancreas commons represent a cause of back pain; hip pain is often confused with low back pain; vascular problems, like abdominal aortic aneurysms could present as back pain. Therefore, the patient

must be evaluated by a competent physician and a diagnosis must be made prior to treatment because under this scenario, the patient many weeks after failed continued treatment is finally evaluated by a physician and the patient is found to have a malignancy. These conditions could have been missed and the patient continues with the treatment without the diagnosis.

Another note about the education background. You must understand that the educational program in most instances represents two years of training, one year of which is in a classroom, and the second year or six months is for the most part a clinical apprenticeship. Therefore, nowhere in their educational program is there any significant amount of education in regard to diagnosis of a whole variety of medical conditions - orthopaedic and non-orthopaedic conditions, which commonly represent potential indications for physical therapy. But, there are many other conditions that the physician understands through his training and background, which represent contraindications, where patients should not be sent for physical therapy. The patients may have other conditions that require other kinds of treatment for common disorders such as back pain where physical therapy would not be the appropriate treatment, but instead evaluation of a kidney tumor may be more appropriate.

Another matter is the clinical consideration of when to begin and when to stop treatment and how this physical therapy treatment relates to the use of various medications. For example, a patient usually receives various types of pain medication or important types of anti-inflammatory drugs that have potential significant side effects concurrently with physical therapy. The use of these medications in combination with the therapy represents critical decision-making. It is also important to have the physician, not only evaluate the patient initially but, to reevaluate the patient to determine whether or not physical therapy should be continued and how this physical therapy may be continued or whether or not medication should be stopped, increased, or managed in some other fashion.

The next important point is the economic impact. Orthopaedic Surgeons under current guidelines do not own and operate Physical Therapy facilities; however physical therapists do. Therefore, the economic motivations of the physical therapist must clearly be suspect. The "gatekeeper" for control of the physical therapy treatments must be the physician. The physician has no economic interest in continuing physical therapy treatments; however, the physical therapist clearly does. Because there are no controls on the limits of treatment, when to begin, how to continue, when to stop, the physical therapist is put into a position where they have an inherent conflict of interest in regard to continuing the

treatment. Without anyone looking over their shoulder, there are enormous financial rewards that would result from this continued physical therapy treatment. This alone is reason enough for not passing the Bill. There will be a tremendous increase in physical therapy costs, which will be shocking to everyone.

The last consideration is the legal responsibility of the physical therapist and the change in legal responsibility in regard to the referring Orthopaedic Surgeon or other physician. If an Orthopaedic Surgeon refers a patient to a physical therapist, he has some burden of responsibility since he makes a diagnosis. However, he has no responsibility if the physical therapist treats without a diagnosis. In addition, the Orthopaedic Surgeon is put into a very difficult position of evaluating these patients after treatment has been initiated with either no diagnosis or a mistaken diagnosis by the physical therapist. A difficult relationship is, therefore, expected to develop between the physician and the physical therapist because the legal consequences of misdiagnosis by the physical therapist who is not trained to make a diagnosis are obvious. In the past, Orthopaedic Surgeons commonly have "protected" the physical therapist because they were carrying out instructions developed by the Orthopaedic Surgeon. However, under these conditions, the Orthopaedic Surgeon will be more interested in protecting himself and clearly an adversarial relationship will develop at the professional level between the Orthopaedic Surgeon and

the physical therapist. This would also certainly apply to other specialties of medicine, which historically in the past have referred patients to the physical therapist. The nature of the liability insurance in the proposed Bill is obviously inadequate and far less than that of a physician.

Therefore, on behalf of the Orthopaedic Surgeons in Pennsylvania and the Pennsylvania Orthopaedic Society, it has been my privilege to bring you this testimony in regard to the public danger of passing this Bill that would enable physical therapists to treat patients without referrals from physicians and without a diagnosis. It would certainly open up a Pandora's Box. The considerations that have been emphasized are: the lack of educational background to make a diagnosis; the inability to determine the role of other treatments used concurrently such as medications, when to stop these medications, when to start others; the economic and "gatekeeper" aspects in regard to the projected increased cost to the public for physical therapy services; and the legal consequences - both to the practicing physicians, as well as to the overall liability situation.

Physical Therapy is a fine profession and physical therapists should continue to work in a cooperative manner with physicians.

Thank you for your consideration. I would be pleased to answer any questions.

**TAB FOUR**

## **MATERIAL FROM PHYSICAL THERAPISTS WITH RESPONSES FROM THE ORTHOPAEDIC COMMUNITY**

- I. Physical Therapists' Study Entitled "A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy" *Physical Therapy, Volume 77, Number 1, January 1997*
- II. Analysis of "A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy" *Cynthia Shewan, PhD., American Association of Orthopaedic Surgeons*
- III. Analysis of "A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy" *Peter L. Meehan, MD, Georgia Orthopaedic Society*
- IV. Physical Therapists' Advocacy Literature on Direct Access *American Physical Therapy Association*

# Research Report

## A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy

**Background and Purpose.** Access to physical therapy in many states is contingent on prescription or referral by a physician. Other states *have* enacted direct access legislation enabling consumers to obtain physical *therapy without a physician referral*. Critics of direct access cite potential over-utilization of services, increased costs, and inappropriate care. **Methods and Results.** Using paid claims data for the period 1989 to 1993 from Blue Cross-Blue Shield of *Maryland, a direct access* state, we compiled episodes of physical therapy for acute musculoskeletal disorders and categorized them as *direct* access (n=252) or physician referral (n=353) using algorithms devised by a clinician advisory panel. *Relative* to physician referral episodes, direct access episodes encompassed fewer numbers of services (7.6 versus 122 physical therapy office visits) and substantially less cost (\$1,004 versus \$2,236). **Conclusion and Discussion.** Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. There are several potential reasons why this may be the case, such as lower severity of the patient's condition, over-utilization of services by physicians, and underutilization of services by physical therapists, Concern that direct access will result in over-utilization of services or trill increase costs appears to be unwarranted- [Mitchell JM, *de Lissovoy G. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy- Phys 77ier- 1997; 77:10-18.*]

**Key Words:** *Direct access, Episode of care, Physical therapy, Physician referral.*

In many states, the practice of physical therapy *is* contingent on the prescription or referral by a physician, a requirement that effectively limits access to physical therapy services. Other states have enacted legislation permitting direct access--the ability of a health care consumer to freely visit a physical therapist without first securing referral from a physician. In these states, *licensed therapists* may evaluate patients without referrals and make autonomous decisions about subsequent clinical management.<sup>1</sup>

Although direct access in the United States dates back to 1957, the majority of states with direct access statutes have permitted physical therapists to treat and evaluate patients without physician referral only since the 1980s.<sup>2</sup> No published research has evaluated the impact of physician referral versus direct access on utilization and costs of care for persons undergoing physical therapy. This exploratory study compared the utilization of health care resources and third party medical expenditures for persons receiving physical therapy under direct access versus those referred for such services by a physician.

We begin this report by *providing* some background on direct access to physical therapy. Next, we describe a study method based on the analysis of episodes of physical therapy created using Blue Cross-Blue Shield claims data. The final section discusses empirical results, study limitations, and implications for public policy.

## Background

Thirty states allow physical therapists to treat and evaluate patients without *physician* referral, *and an* additional 14 states allow physical therapists to evaluate, but not treat, patients without referral.<sup>2</sup> Twenty states and the District of Columbia *require physician* referral as a prerequisite for treatment by a physical therapist.<sup>1</sup>

Advocates for physical therapists to have direct access argue that direct access extends consumers' choice of health care providers, improves access to services that promote prevention and rehabilitation, and reduces delays before commencing therapy. Proponents further argue that direct access may result in cost savings by avoiding the referring physician's fees and related ancillary services (e.g., roentgenograms, laboratory tests). Supporters of direct access also point out that other non-*physician* providers, such as chiropractors and clinical psychologists, do not require *physician referrals or* screening evaluations.<sup>1,5</sup>

Critics of direct access argue that physical therapists may overlook serious medical conditions and for this reason contend that all patients should be screened initially by physicians.<sup>1,3</sup> The American Medical Association (AMA) contends that although allied health care professionals are useful as physician extenders, they would not serve the public as well in an autonomous role.<sup>4</sup> The AMA and the American Academy of Orthopaedic Surgeons oppose independent practitioner status for physical therapists

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This research was supported by the American Physical Therapy Association.

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because of concerns about improper diagnosis, inappropriate care, and the potential for increased costs.<sup>5</sup> State medical societies and chiropractic groups have also been major adversaries of direct access. A common concern is that direct access legislation may lead therapists to diagnose and treat beyond their level of competency, thus erroneously assuming the role of physicians.<sup>6,7</sup>

Previous research on direct access to physical therapy has considered the incidence of direct access practice, patient and provider satisfaction with physical therapy received under direct access<sup>2,10</sup> and physical therapist and patient opinions about direct access to physical therapy.<sup>13</sup> The limited available evidence from these published studies indicates that direct access has had only a minimal impact on physical therapy practice.<sup>1,8-10</sup> In some of these studies,<sup>1,10</sup> however, physical therapists expressed greater job satisfaction and patients preferred the more expeditious treatment received.<sup>1,10</sup>

## Method

### *The Data*

The study is based on health insurance claims data furnished by Blue Cross-Blue Shield of Maryland. This insurer has been reimbursing for physical therapy provided under direct access since 1986, so the coverage is well established. Group insurance paid claims represent a broad cross section of the employed population and their dependents. Because these individuals obtained health insurance through employer-sponsored plans, the effect of adverse selection, which characterizes persons with individual policies (or no insurance), is minimized. Although the data encompassed a number of different employer groups, the range of services covered and the level of reimbursement among groups in the sample were virtually identical. The plans covered only working-age adults and their children; persons eligible for Medicare (age 65 years and over) were not examined.

The data set included all paid claims for the calendar years 1989 through mid-1993. The initial file contained 1.7 million claims in four categories: professional fees, outpatient services (i.e., radiology, laboratory, and ancillary services),<sup>1</sup> prescription drugs, and hospitalization. Each record contained a unique beneficiary identification number, date of service, type of service, submitted charge, amount reimbursed by Blue Cross-Blue Shield, and subscriber co-payment amount. Claims for professional services also included a designation of clinical specialty (e.g., licensed physical therapist, orthopedic physician, chiropractor), Current Procedural Terminology (CPT) code for type of service, and ICD-9-CM (*International Classification of Diseases, 9th 1 revision. Clinical Modification*) diagnostic code for the condition.

### *Analytical Framework--Episodes of Physical Therapy*

Health insurance claim files comprise a series of discrete transactions that document beneficiary encounters with the medical care system. Claims records can be grouped sequentially to construct "episodes of care" that encompass a series of temporally contiguous health care services related to treatment of a specific illness or health condition.<sup>14</sup> Recent studies have used the episodes framework to examine the decision to seek medical care, subsequent utilization of services, and expenditures.<sup>14-20</sup>

The main advantage of using claims data for health services research is that observations on a large number of individuals over an extended period of time can be obtained at relatively low cost. When compared with audits of medical records, this method for assessing medical care has limitations. First, only sparse information is available for each encounter, and this information has been collected for administrative rather than clinical purposes. Second, the validity of episode construction is contingent on algorithms created by the investigator. Error may arise from either the inclusion of irrelevant transactions or the exclusion of transactions actually related to the condition of interest. Third, a subject's health history and clinical status at the start of an episode must be inferred from the pattern of prior claims. Similarly, outcome of treatment following an episode must also be deduced from the presence (or absence) of subsequent claims. Finally, medical expenditures paid directly by the patient, such as charges for over-the-counter drugs, are not documented (although this is also true of medical records).

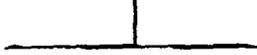
Episodes of physical therapy were constructed with guidance from an advisory panel of five licensed health care professionals practicing in Maryland. Panel members were selected from a list of candidates provided by the Maryland Physical Therapy Association in response to a request for names of active practitioners specializing in physical therapy and orthopedic medicine. The panel consisted of three physical therapists and two physicians (an orthopedic surgeon and a physical medicine/rehabilitation specialist). Additional insight on the idiosyncrasies of the claims data was provided by the medical director of Maryland Blue Cross-Blue Shield. Panel functions were to develop criteria for constructing episodes of care and to establish rules for classifying episodes as either direct access or physician referral.

An episode of physical therapy should encompass all services provided in relation to a specific illness or condition during a suitable time period.<sup>14</sup> At the time of this study, physical therapy performed by a licensed physical therapist was billed under "physical medicine" procedure (CPT) codes. Other health care professionals such as physicians and chiropractors also utilize these CPT codes for services performed, even though they are not licensed physical therapists and thus may not be performing identical services. For purposes of classification, we refer to episodes of care defined by physical medicine procedures as physical therapy, irrespective of the health care provider who rendered the service.

Did the 30-day MAW prior to the start of the episode contain a physician out of office CPT Code where the provider of practice is a physician

NO

Does physician claim include ICD-9-CM Code?



Was the provider of first physical medicine service in the episode a licensed physical therapist?

YES

No (CD-9-CM code)

cannot the  
musculoskeletal  
group?

No-other code  
No-field of practice not a licensed physical therapist

yes CD-9-CM

Do CPT codes indicate that physical therapy visit included evaluation or diagnostic procedures?



Other Yes-Work No4ack field a evaluation initial Practice diagnostic codes

or diagnostic

evaluation OR

Category 1      Category 2      Category 3      Category 4      Category 5      Category 6      Category 7      Category 8

musculoskeletal  
ICD-9-CM Code

Figure. Algorithm for categorization of episodes of core (CPT=Current Procedural Terminology, ICD-9-CM=International Classification of Diseases, 9th Revision, Clinical Modification). Note: musculoskeletal ICD-9-CM codes include 710-739 and 840-8d8.

We first identified all individuals who had at least one physical therapy claim during period January 1990 through December 1991. Approximately 11,600 individuals met this criterion. We then sorted each individual's claims for the period 1989 through 1993 in chronological order by date of service and created a window of observation extending from 12 months prior to the date of the first physical therapy service to 12 months after the last physical therapy, service. This window contained all or part of one or more episodes of care.

Criteria for marking an episode's beginning and end points were devised by the advisory panel. We examined the 30-day period prior to the first physical therapy claim that occurred during the period January 1990 through December 1991. If no physical therapy claim occurred during the 30 days preceding the first physical therapy service, this date marked the beginning of an episode of care. If a physical therapy claim did occur within that 30-day period, the next 30-day period prior to that claim was reviewed. This process was repeated for each preceding 80-day period until reaching the initial transaction in the data set (January 1, 1989).

We then identified the last physical therapy service that occurred during the period January 1990 through December 1991. The panel recommended examining a 45-day period subsequent to this encounter. If no physical therapy claims were recorded during this 45-day period, then the last physical therapy service marked the end of the last episode. Alternatively, if a physical therapy service was recorded during this subsequent 45 days, the episode was deemed incomplete and the next 45-day period following the physical therapy service was examined. Again, this procedure was repeated until reaching the end of the data set (December 31, 1992). Using this approach, we created a new file containing observations on approximately 1,500 persons who had at least one episode of physical therapy that began and ended during the period 1989 through 1992.

These beginning and end points could actually mark different episodes. For this reason, we next examined the 45-day period occurring after the date established as the commencement point of the episode denoted by the first physical therapy service in order to distinguish among multiple episodes. If a physical therapy encounter occurred within 45 days after the commencement of an episode, the two encounters were considered part of a single episode. This procedure was repeated for all subsequent physical therapy services. If a period of 45 days occurred in which there was no physical therapy service, then the date of the last physical therapy service prior to the 45 days in which no physical therapy services were rendered marked the end of the episode. If another physical therapy service was observed beyond this 45-day post-treatment period, then this date marked the commencement point of another episode.

## **Classification of Episodes**

After creating episodes of physical therapy, the next task was to classify episodes as either direct access or physician referral. Because claims data do not differentiate direct access episodes from those that were referred, we adopted decision rules recommended by the advisory panel. The classification algorithm, depicted in the Figure, differentiated eight categories of episodes.

We first examined the 30-day period prior to the first physical therapy service within each episode to determine whether there was a claim for a physician service with either ICD-9-014 codes or CPT codes indicating a condition that could reasonably lead to the provision of physical therapy. The panel recommended a focus on only acute and sporadic musculoskeletal-related disorders (ICD-9-CM codes 710-739 and 840-848). The 30-day period was deemed conservative because a typical person receiving a prescription for physical therapy could likely schedule an initial appointment within 2 weeks. We then determined whether claims for physical therapy services within the episode were rendered by a licensed physical therapist in order to exclude physical therapy services rendered by other providers (e.g., chiropractors). If these criteria were met, the episode was classified as a physician referral (category 3).

Episodes for which there was no indication that a physician encounter occurred in the 30-day period preceding the first physical therapy service were then examined to determine whether services were provided by a licensed physical therapist. Category 7 contained episodes in which claims for diagnostic or evaluation procedures were recorded for the first encounter with the physical therapist. Criteria for category 8 were identical to those for category 7 except that no initial claims for diagnostic evaluation were observed. Categories 7 and 8 were grouped together and comprise the direct access episodes. Other categories (1, 2, 4, 5, and 6) did not meet the criteria for either direct access or physician referral and were excluded from the analysis.

We then visually inspected the set of transactions comprising episodes in categories 3, 7, and 8. Following recommendations of the advisory panel, we excluded episodes that involved claims for chronic musculoskeletal conditions (e.g., arthritis, cancer, multiple sclerosis, osteoporosis). We also excluded episodes in which the patient appeared to have multiple comorbidities. These episodes tended to contain visits to a number of different providers for a range of health problems, making it impossible to determine whether physical therapy received by the patient represented treatment for the initial encounter with a musculoskeletal diagnosis. The final analysis file comprised 252 direct access and 353 physician referral episodes.

### **Statistical Analyses**

We first compared the mean values of utilization and cost variables for direct access versus physician referral episodes using a two-tailed test for differences between means, with a null hypothesis of no difference (Tab. 1). Because simple comparisons do not control for confounding factors, we also used multiple regressions analysis to compare direct access and physician referral episodes with respect to utilization (number of physical therapy visits) and costs. Definitions of variables used in the analysis are presented in Table 2. Summary statistics for the dependent and explanatory variables follow each definition.

**Table 1.**  
**Comparison of Mean Values for Resource Utilization and Cost in Direct Access Episodes Versus Physician Referral Episodes**

Variable	Direct Access (n=252)	Physician Referral (n=353)	Difference (p < 0.01)
Physical therapy claims	20.2 (82.9)	33.6 (39.0)	13.4
Physical therapy office visits	7.6 (9.1)	12.2 (12.8)	4.6
Physical therapy claims paid (\$1)	566 (716)	890 (941)	324
Drug maims	1.47 (4.0)	3.13 (7.72)	1.66
Drug claims paid (\$)	36 (109)	78 (223)	42
Radiology claims	0.32 (1.03)	1.02 (1.86)	0.70
Radiology claims paid (\$)	44 (190)	175 (541)	131
Hospital admissions	0.25 (0.80)	0.64 (1.17)	0.39
Hospital admissions paid (\$)	83 (402)	397 (1,003)	315
Total claims paid (\$)	1,004 (2,030)	2,236 (2,827)	1,232

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**Table 2. Definitions of Variables Used in Regression Analyses**

Dependent	Natural logarithm of the count of physical therapy office visits during the episode (X=1.78, SD= 1.12)
Logarithm-physical therapy visits	
Logarithm-physical therapy paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for physical therapy services received by patient during the episode (X=6.03, SD=1.26)
Logarithm-total paid	Natural logarithm of total dollar amount reimbursed by Blue Cross-Blue Shield for all services received by patient during the physical therapy episode (X=6.61, SD=1.48)
Independent	Dichotomous variable: 1 if episode was direct access (category 7 or 8), 0 if episode was physician referral (category 3) (X=0.58, SD=0.49)
Direct access	
Female	Dichotomous variable: 1 if the beneficiary gender was female, 0 if male (X=0.63, SD=0.48)
Age	Beneficiary age (in years) (X=42.19, SD= 12.5)
Drugs	Dichotomous variable: 1 if the episode contained any claims for prescription drugs, 0 if otherwise (X=0.42, SD=0.49)
Hospital	Dichotomous variable: 1 if the episode contained any claims for inpatient or outpatient services provided by an acute care general hospital, 0 if otherwise (X=0.25, SD=0.44)
Radiology	Dichotomous variable: 1 if the episode contained any claims for diagnostic radiology services provided by a physician or freestanding imaging center, 0 if otherwise (X=0.29, SD=0.46)
Direct access-drugs	Interaction of “direct access” and “drugs”: 1 if a direct access episode contained prescription drug claims; 0 if otherwise (X=0.12, SD=0.32)
Direct access-hospital	Interaction of “direct access” and “hospital”: 1 if a direct access episode contained claims for hospital services, 0 if otherwise (X=0.55, SD=0.23)
Direct access-radiology	Interaction of “direct access” and “radiology”: 1 if a direct access episode contained diagnostic radiology claims performed at a physician office or freestanding imaging center, 0 if otherwise (X=0.55, SD=0.23)

The total cost of each episode of physical therapy was computed as the sum of all paid claims for services and drugs provided during the episode. A logarithmic transformation was performed on the dependent variables to adjust for observed right-skewed distribution, which is typical of medical utilization and expenditure data.<sup>21</sup> The primary explanatory variable of interest was referral status. The dichotomous variable “direct access” identified episodes in categories 7 and 8 while category 3 (physician referral) served as the reference category. Three dichotomous variables were constructed to identify episodes that contained any claims for hospital services (hospital), pharmaceuticals (drugs), and diagnostic imaging rendered via a physician’s office or freestanding center (radiology). All three categories of service must be prescribed by a physician and thus suggest greater severity of illness than episodes not including these services. To further distinguish episodes involving any or all of these services by referral status, we constructed interaction terms. These terms identified direct access episodes that involved claims for hospital services (direct access-hospital), pharmaceuticals (direct access-drugs), and imaging procedures (direct access radiology). Additional variables controlled for age and gender.

## Results

Table 1 shows simple comparisons using tests for differences between means. Physician referral episodes were characterized by 13.4 (67%) more physical therapy claims and 4.6 (60%) more office visits than direct access episodes ( $P < .0001$ ). Reimbursements for physical therapy services were, on average, \$324 (57%) more expensive for physician referral episodes when compared with direct access episodes ( $P < .0001$ ). Total paid claims averaged \$2,236 for physician referral episodes and \$1,004 for direct access episodes; this \$1,232 difference signifies that the cost to Blue Cross-Blue Shield for physician referral episodes exceeded the cost for direct access episodes by about 123% ( $P < .001$ ).

Table 3 displays the results of regressions where the dependent variables were the number of physical therapy visits, paid claims for physical therapy services, and total paid claims for all services and drugs. In each case, the dependent variable has been transformed and is expressed as its natural logarithm. Adjusted multiple regression ( $R^2$ ) values indicate that models account for about 25% of the variation in the logarithm of physical therapy visits and for about 21 % for the logarithm of physical therapy claims.

**Table 3. Regression Estimates for Number of Physical Therapy Visits, Paid Claims for Physical Therapy Services, and Paid Claims for All Services**

Independent Variable	Number of Physical Therapy visits (Log)	Paid Claims for Physical Therapy Services (Log)	Total Paid Claims for AN 5mrvicrs and Drugs (Log)
Direct access <sup>b</sup>	-0.503** (0.111)	-0.519** (0.134)	-0.864** 10.125)
Drugs	0.361 ** (0.10488)	0.346** (0.124)	0.425** (0.116)
Hospital	0.268* 10.121)	0.274 (0.142)	0.934** (0.134)
Radiology	0.479** (0.117)	0.534** (0.138)	0.853** (0.130)
Direct access-hospital <sup>c</sup>	0.127 (0.251)	0.106 (0.295)	0.133 (0.269)
Direct access drugs <sup>c</sup>	0.601 ** (0.178)	0.644* (0.210)	0.685** (0.198)
Direct access-radiology <sup>c</sup>	-0.298 (0.248)	-0.107 (0.292)	0.249 (0.272)
Female <sup>b</sup>	0.112 (0.083)	0.161 (0.098)	0.149 (0.092)
Age	-5.643 (0.003)	-0.002 (0.004)	-0.002 (0.004)
Constant <sup>c</sup>	1504** (0.155)	5.756** (0.184)	6.191 ** (0.173)
Adjusted R <sup>2</sup>	0.247	0.212	0.479
F statistic	22.94	17.34	61.79

- a) Standard errors of regression coefficients are in parentheses. Single asterisk (\*) indicates P < 0.005; double asterisk(\*\*) indicates P < 0.01.
- b) Reference category for “direct access” is “physician referral”; reference category for “female” is “male.”
- c) Interaction term between “direct access” and named variable.

**Table 4.**  
**Percentage of Difference in Utilization and Cost for Direct Access**  
**Episodes Relative to Physician Referral Episodes\***

Model Dependent Variable	Difference Relative to Physician Referral Episode
Number of physical therapy visits	-65%
Paid claims for physical therapy services	-68%
Total paid claims for all services and drugs	-137%

\*Based on regression results shown in Table 3.

The regression explains 48% of the variation in total paid claims for all services and drugs.

In each model, the coefficient for the variable “direct access” was negative ( $P < 0.01$ ), implying that episodes of physical therapy classified as direct access involved fewer visits and lower costs relative to episodes classified as physician referral. Coefficients for the variables identifying episodes of physical therapy that included claims for drugs, hospitalizations, or radiology were positive and significant at  $P < 0.01$ . These findings imply that physician referral episodes with claims for any or all of these services are characterized by more physical therapy visits, higher paid claims for physical therapy services, and higher total costs per episode relative to physician referral episodes that do not involve drugs, hospitalizations, or imaging procedures.

Interaction terms that identified direct access episodes involving hospital inpatient services or imaging were not significant, implying that such services have little bearing on use of physical therapy or episode costs. By contrast, direct access episodes that contained one or more claims for pharmaceuticals were associated with more physical therapy visits, higher paid claims for physical therapy, and higher total episode costs. The variables controlling for gender and age had negligible effects on both utilization and costs.

Because log-transformed results cannot be interpreted directly, the coefficients for the direct access variables have been converted to percentages (Tab. 4). Relative to physician referral episodes, those episodes classified as direct access involved 65% fewer physical therapy visits and 68% lower paid claims for physical therapy services.

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The lower utilization rates for all services that characterized direct access episodes is best seen by examining total episode costs. When measured in terms of paid claims, direct access episodes were 137% less expensive than those classified as physician referral.

## **Discussion**

Thirty states have legislation enabling patients to obtain physical therapy services without physician - referral (direct access). The public policy objective for direct access statutes is to give the consumer the ability to select the most appropriate source of care. Consumers, however, should be protected against under provision of care that could occur if physician services were not provided when medically necessary.

Using Blue Cross-Blue Shield claims data from Maryland (a state with direct access statutes), we compared episodes of physical therapy categorized as direct access relative to those classed as physician referral and found substantial differences. Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classed as physician referral. Some direct access episodes included claims for inpatient hospital care, drugs, or outpatient radiology-all services requiring physician prescription. The use of hospital services or imaging procedures during direct access episodes had a negligible relationship with the number of physical therapy visits or episode costs. In contrast, direct access episodes that contained claims for drugs were associated with greater use of physical therapy and higher costs. Physician referral episodes that included any or all of these three items were associated with higher utilization and costs.

Because our study was based on health insurance claims data, these findings must be interpreted with caution. The method relied on sorting algorithms to identify episodes of care and to distinguish direct access from physician referral. We cannot be certain that resource use attributed to episodes and their classification accurately identified each patient's course of therapy. In addition, we have no way of knowing whether the lower cost of direct access episodes was due to under-provision of care or whether the greater resource intensity and cost of physician referral episodes reflects overprovision of care.

## **Conclusions**

We conclude that direct access episodes, on average, are short in duration and relatively inexpensive. Potential explanations why this may be the case include lower severity of the patient's condition, over-utilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in over-utilization of services or will increase costs appears unwarranted. The fact that some direct access episodes included physician-prescribed services indicates that physical therapists are making referrals to physicians. Thus, our study offers evidence that public policy objectives for direct access to physical therapy services are being achieved.

## **Acknowledgments**

We acknowledge the invaluable guidance provided by advisory panel members Richard Hinton, MD, Cindy Juris, MD, Annette Iglarsh, PhD, PT, Rod Schlegel, PT, and Mark Valente, PT. Insight on use of Maryland Blue Cross-Blue Shield claims data was provided by Alan Wright, MD. Chuanfa Guo provided expert computer programming in construction of episode-of-care files. Emily Tobias Shumsky assisted in the detailed inspection of final-analysis files. Comments on an earlier version of this manuscript were provided by Jack Hadley, Vivian Hamilton. and Robert Hurley.

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## **A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy**

Jean Mitchell Ph.D. and Gregory de Lissovoy Ph.D.

Review by Cindy Shewan, Ph.D.

This paper is a retrospective analysis of claims submitted to Blue Cross/Blue Shield of Maryland. It is published in *Physical Therapy* and was supported by a grant from the American Physical Therapy Association. Based upon the nature of the paper and the fact that it was done with the support of the Physical Therapy Association I assume that this does not represent a peer reviewed article.

Since the natural history of most conditions is that of self-resolution a major question to be asked is whether the cases of direct referral had problems that actually needed treatment. It may be argued that most of the direct access costs are for treatment that may not be necessary. For patients to wait to see a physician their problem may have resolved before they even saw the physician or they might be told that no treatment is the appropriate approach to their problem.

The authors refer to the paper as an “exploratory study comparing the utilization of health care resources and third party medical expenditures for persons receiving physical therapy under direct access versus those referred for such services by a physician.” (p 11 column 1 para 2 lines 8-12)

The methodology used in this paper cannot identify patients who used direct access to a physical therapist. Some of the patients who the authors considered to have had direct access actually would have had physician contact prior to their physical therapy encounter. The construction or design of the study with their exclusion criteria eliminated from analysis patients who used direct access but who had more what were termed chronic problems, thus introducing a selection bias to milder self-limited conditions.

I do not think that any conclusion can be drawn from this paper.

### Specific Comments:

#### 1. p.11 column 2 para 1

This section is unclear. In one sentence the authors state that 30 states allow physical therapists to treat and evaluate patients without physician referral with 14 states permitting evaluation but not treatment without physician referral. In the next sentence it is stated that 20 states plus the District of Columbia require physician referral as a prerequisite for treatment.  $30 + 14 + 20 = 64$

#### 2. p 11 column 2 para 2

Advocates of direct access argue that such a measure expands consumers' choice of health care providers, improves access to services that promote prevention and rehabilitation and reduce delay in commencing therapy. Direct access may result in cost savings by avoiding physician referral fees and related services-X-ray, laboratory exams, etc.

This section assumes that all pain and other problems require physical therapy. It further discounts the importance of diagnosis prior to the institution on treatment. It also states that patients have the ability to self diagnose their problems.

#### 3. p 12 column 2 para 2

Maryland has been a direct access state since 1986. The data is based on claims on patients who are working age and their children.

There is no clinical data reviewed in this study. Therefore the specific nature of a patient's problem is not known and the severity not measurable. The methodology used assumes that a patient was well before their first encounter and was well after their last evaluation. End point is based upon the absence of future claims.

4. p 14 column 1 para 2 lines 3-6

It is stated that claims data from BC/BS does not distinguish direct referrals from physician referrals.

5. p 14 column 2 para 2 Inclusion Criteria

Several pathways were constructed to estimate or guess whether a patient saw a physical therapist directly or whether a physician referred them to a therapist. One of the groups they concluded were direct access patients were a group who had had some type of diagnostic test or "evaluation procedure" immediately prior to seeing a physical therapist. Since therapists are not permitted to order radiographic studies or laboratory studies I do not think that it is appropriate to assume that this category of patient was not seen and evaluated by a physician prior to seeing a therapist. See Comment # 4.

6. p 14 column 2 para 3 Exclusion Criteria

Patients judged to have chronic musculoskeletal conditions such as arthritis, cancer, multiple sclerosis, osteoporosis, and patients with comorbidities. Using these exclusion criteria the study has selected for conditions that are most likely to be self-limited. The study's conclusions will be self evident with the criteria.

7. p 15 column 1 para 1 lines 1-2

"The total cost of each episode of physical therapy" was computed as the sum of all paid claims for services and drugs provided during the episode. Since physical therapists cannot prescribe medications and since insurance companies do not pay for over the counter medications these episodes must have had physician contact. These patients are unlikely to represent direct access.

8. p 15 column 1 para 1 lines 15-18

The authors acknowledge that when patients have been referred by a physician there is an implied greater severity of illness.

9. p 15 column 1 para 1 lines 20-25

Refer to direct access to hospitals, pharmaceuticals, and imaging procedures in this section. Please clarify.

10. p 15 para 2

Results Report that there are more claims with physician referral and a greater cost. See Comments #6 and 8. In this section and thereafter the authors use percents in reporting their data without the numerator denominator data.

11. p 16 column 2 para 3

An example of the problem noted in Comment #10 is the statements that direct access resulted in 65% fewer physical therapy visits and 68% lower cost.

12. p 17 column 1 para 2

“The public policy objective for direct access statutes is to give the consumer the ability to select the most appropriate source of care.” This implies that it is the patient who is to make the diagnosis and plan their treatment for given problem. Whose public policy is this?

13. p 17 column 1 para 3

In this section they argue that direct access episodes were shortened, encompassed fewer visits, etc. See Comment # 6.

14. p 17 column 1 para 3 lines 10-13

They acknowledge here that some of their direct access patients had episodes that included inpatient hospital claims, drugs, or outpatient radiology that required physician prescription.

15. p 17 column 1 para 3 line 14

Episodes that included drugs were associated with greater use of physical therapy services. This group of patients has also been seen by physicians and by definition would have a more severe problem.

16. p 17 column 1 para 4

The authors state that their data must be interpreted with caution. They further state that they cannot be certain that their data permitted accurate analysis of each patient’s course of therapy.

The methodology and information used to write this paper cannot identify with accuracy patients who truly were direct access. Without diagnosis and results of treatment data no conclusions can be made. The exclusion criteria used eliminated patients who may have actually been direct access but who would have required long term and complicated care.

## **A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy**

Jean Mitchell Ph.D. and Gregory de Lissovoy Ph.D.

Review by Peter Meehan, M.D.

An overall comment on the article is that the data do not demonstrate that the direct access (DA) and physician referral (PR) groups are comparable either on the types of disorders included in the groups or on the severity of the disorders being compared. What this means is that the authors have not demonstrated that they are comparing apples with apples; they may be comparing apples with oranges.

The authors also do not state whether the outcomes of these two groups (DA UUUUUUUUUU [vs. PR](#)) were comparable. This is important to know from a cost benefit point of view. If the outcomes of the PR group are better despite a higher cost, this is a very different situation from both higher cost and the same or poorer outcomes in the PR group.

Several comments can be linked to specific portions of the article.

p. 12

If direct access had only minimal impact on physical therapy practice, what is the reason(s) to grant it?

p. 12

The selection of claims for the article may not be representative of orthopaedists' claims as a whole. Selecting only Medicare claims includes only the population over the age of 65 years. Since only 25% of orthopaedists' cases are in this age group, the study does not capture the large majority of orthopaedic practice. In addition, orthopaedists report that only 20.9% of their patients are Medicare patients.

p.12

The Maryland PT Association selected the advisory panel. To ensure an unbiased panel selection, it would have been appropriate to have also asked the Maryland State Orthopaedic Society.

p. 13

The authors present no clear evidence that PT episodes did not also include other providers. This issue is important when selecting episodes of care. In fact, the authors state, "For purposes of classification we refer to episodes of care defined by physical medicine as physical therapy, irrespective of the health care provider who rendered the service."

P. 14

The accepted episodes that were included in the study included only a small portion of the types of cases that an orthopaedist sees. Notably excluded were arthritis, osteoporosis, multiple sclerosis, and cancer, as well as cases with multiple comorbidities.

p. 16

“Interaction terms that identified direct access episodes involving hospital inpatient services or imaging were not significant, implying that such services have little bearing on physical therapy or episodes costs.”

Intuitively, this statement seems wrong. Hospital and imaging are expensive and therefore, intuitively, would seem to affect episode costs.

p. 17

The last paragraph of the discussion section really summarizes several issues in question, that is, several weaknesses of the study.

- The study relied on sorting algorithms to identify episodes of care and direct vs. physician access. Accurate sorting algorithms are critical to the credibility of the results of the study.
- The authors state they cannot be certain that resource use attributed to episodes and their classification accurately identified each patient's course of therapy. If one is going to use resource utilization as a comparison variable, its measurement must be accurate.
- The authors admit that lower cost may be due to either underutilization with DR, that is, patients should have received more services and did not or to over-utilization with PR, that is, patients received services they did not need. In the first scenario, DA may have been cheaper, but the quality of care would have been poorer.
- The authors did not address the comparability of the severity of cases in the DA and PR groups. Therefore, there is no way of knowing if the study compared similar patient groups. If patients in one group were more severe, it would stand to reason that they would require more care and perhaps more expensive care and, therefore, the costs would be higher. Different levels of severity could be the explanatory variable rather than DA or PR.



**Evaluation of “A Comparison of Resource Use and Cost in Direct Access versus Physician Referral Episodes of Physical Therapy”**

**Garr Newman & Associates, LLC**

**Dec. 23, 2000**

Garr Newman & Associates, LLC was asked to conduct a critical and objective evaluation of the article “A Comparison of Resource Use and Cost in Direct Access versus Physician Referral Episodes of Physical Therapy.” The article appeared in *Physical Therapy*, Volume 77, Number 1, January 1997. The authors of the article, Jean M. Mitchell and Gregory de Lissovoy, are respected health services researchers. The American Physical Therapy Association supported the research.

The evaluation of the article includes six tasks:

Conduct a literature review;

To determine if the major and/or secondary objectives of the paper are met;

Review and analyze the evaluation design;

Review and critique the data collection methods and measurement methods;

Critique the statistical methods employed;

Overall Conclusion.

## **Literature Review**

The purpose of the literature review is to determine if there are more recent research findings on costs and use of services comparing direct access versus physician referrals for physical therapy services. Such information is useful in comparing research methods and statistical results with those in the study under review.

We conducted a literature review of several well-known medical, health services research and economic databases, all of which are available on the Internet. We found no comparable research studies published since 1997. We located one article of marginal interest by Crout, Tweedle, and Miller, “Physical Therapists’ Opinions and Practices Regarding Direct Access,” which appeared in the January 1998 issue of *Physical Therapy*. The study was a mail survey of a sample of physical therapists in Massachusetts and Connecticut. While approximately 75% of the respondents in both states were supportive of direct access, the fact that the remaining 25% did not may reflect a less than unanimous support of direct access within the physical therapy profession.

### **Analysis of Major and Secondary Objectives**

Because of a lack of research in the area of direct access, the authors conducted an “*exploratory study*.” The purpose of the study is to compare the “utilization of health care resources and third-party medical expenditures for persons receiving physical therapy under direct access versus those referred for such services by a physician.” Exploratory studies, by their nature and design, are to gain some knowledge and insight in a specific area of inquiry. This is in contrast to “*explanatory*” research, the purpose of which is to test hypotheses and to establish cause and effect relationships. Thus, we can assume that at the outset, the authors were not attempting to conduct a definitive explanatory study of differential cost and use of services under direct access compared to physician referral. Had the study been explanatory, it would have more appropriate to be published in a “top 10” referred health services research journal such as *Inquiry*, *Medical Care*, or *Health Services Research*.

Based on comments made by the authors, there are several assumptions that on the surface support the position that direct access is preferred or should co-exist with physician referrals. First, direct access increases consumer freedom of choice of providers. While this may be true, there is no reason to suppose that greater access results in lower costs, fewer services, or appropriate quality care. Patients who self-refer directly to a physical therapist run the risk of having conditions misdiagnosed and delaying needed treatment that only a physician can provide. As a consequence, they may use more services and have higher costs. Further, it is possible that direct access would lead to higher total costs for physical therapy services because more patients were seeking and receiving care.

Second, many states currently allow direct access. Therefore, the implied logic is that there is merit in expanding the number of states that allow direct access. This is the use of “bandwagon” reasoning to promote direct access.

Third, there is the assumption that physical therapists have clinical skills comparable to physicians for evaluation and treatment and that there are no differences in quality of care. Therefore, direct access is beneficial to patients. To the best of our knowledge, there are no studies that demonstrate comparable or better quality of care through direct access.

Fourth, should a study demonstrate lower costs, lower use of services, and comparable quality of care for direct access compared to physician referrals, an argument in support of direct access could be persuasive. However, it is important to recognize the study does not address the issue of quality in the research design and analysis.

Fifth, the authors review studies, which indicate that direct access has only minimal impact on physical therapy practice. Two of the studies cited reported that physical therapists experienced greater job satisfaction under direct access and that patients preferred direct access, as well. These findings are neither sufficient nor compelling to support direct access. Demonstration of comparable quality of care and lower costs would provide a more convincing rationale.

## **Evaluation Design Critique**

The objective of any research study is to be able to document and make conclusions concerning the phenomenon in question. In the present instance, the authors are concerned with documentation and conclusions on cost and use of services between direct access and physician referral. The choice of an evaluation design has major implications for internal validity and external validity. By internal validity we mean the extent to which the effects observed, i.e. differences in costs and use, are real and not due to competing explanations. By external validity, we mean the extent to which the results can be generalized.

The best and most rigorous research design, which is used extensively in medical research, is an experimental design. A major feature of this type of design is the random assignment of subjects to experimental and control groups. These types of designs maximize internal validity.

The authors employ a non-experimental design, which does not maximize internal validity. They use a procedure whereby health insurance claims data are analyzed and grouped together into episodes of illness categories. As such, there is no random assignment of patients and their claims

data to experimental or control groups. Simply stated, there are two comparison groups. The consequences of using comparison groups compromise internal validity because the groups may differ initially on important demographic, social, or other characteristics.

There are several examples to indicate the problem of research design used and the compromise made to internal validity. For example, we know nothing about how the direct access and physician referral patients differ on income. Hypothetically, it is possible that patients with lower incomes would seek services directly from a physical therapist and higher income patients would access services by physician referral. In addition, wealthier and presumably healthier patients seeking care via physician referral might need fewer and less costly services than patients with low incomes. Thus, the differences between the two groups on cost and access could be due to the difference in income, a measure not used in the analysis. Further, there is no way of knowing if other differences, e.g. ethnicity, education, marital status, etc., occur between the direct access and physician referral groups. If they do exist, then the conclusion of differences between the two groups must be questioned.

In addition, the authors used paid claims data for the period 1989 to 1993. Because this was a state-wide study where the data covered a relatively long time period, it is possible that patients in some areas of the state initially were more (or less) accepting of direct access than in other areas or that greater publicity surrounding direct access occurred in some areas of the state than in other areas. Thus, it is entirely possible that use rates of direct access differed from one part of the state to another. If so, then differences in cost of services and practice patterns might reflect geographic area and other differences and therefore, are biased.

Finally, the fact that the study was confined to Maryland has serious implications for external validity or being able to generalize the results to other states or locations. The study reflects the experience only of Maryland and only of persons who were Blue Cross and Blue Shield subscribers under the age of 65. This population and its social, economic, industry type, and demographic characteristics may be entirely different than the population served by another insurer.

## **Critique of Data Collection Methods and Measurement Methods**

The use of claims data for research purposes is part of an important tradition in health services research. Many important policy-related studies on the demand for health services have

appeared over the years in the most widely respected academic publications. In general, the reliability and validity of (clean) of accurate claims data is not a significant issue.

The authors acknowledge some of the limitations of using claims data. These limitations include, but are not limited to, the limited amount of clinical information available, errors that may arise in the construction of episodes of care, the difficulty in determining the treatment outcomes, and the problem of documenting costs when patients pay for services out-of-pocket. To a greater or lesser extent, these limitations, and others not directly mentioned by the authors, compromise the reliability and validity of the results.

For example, using claims data in an employed population, including dependents, for a Blue Cross and Blue Shield population limits the generalization of the results. These data cannot be assumed to produce the same use and cost results with the use of services for free by the uninsured population, other employment-based insured populations, the Medicare population, or the Medicaid population.

The algorithm and matching procedures used to construct the episodes is problematic. Indeed, a major problem for the researchers is that the Blue Cross and Blue Shield claims data does not allow for the direct classification of direct referrals or physician referrals. Thus, they must construct an algorithm that purports to accurately classify direct and physician referrals. The inability to link all initially eligible claims to episodes, as shown in Figure 1, results in an incomplete picture and biases the results. If no ICD-9-CM code is present (Category 1), then the use and cost for some physician services are excluded. Therefore, the physician referral data in the paper are biased. We have no way of knowing how the bias affects use and cost. Likewise, the lack of initial evaluation or diagnostic codes (Category 8) either underestimates or overestimates the number of services and average costs for direct access physical therapy services.

Another problem with the algorithm is with respect to other providers of services within an episode. On page 17, the authors report that episodes, which included drugs, were associated with greater use of physical therapy services. Since physicians also saw them, this indicates such episodes involved greater patient acuity, which the authors do not take into account. In addition, the authors state that episodes of care are defined by physical medicine as physical therapy, no matter which provider rendered the services. As such, the episodes of care do not allow for a straightforward and meaningful comparison between physical therapy and physician referral episodes.

A major concern for the researchers was to appropriately measure resource utilization. On page 17, the authors acknowledge that they “cannot be certain that resource use attributed to episodes and their classification accurately identified each patient’s course of therapy.” Among other things, their methodology was to use the primary ICD-9-CM or CPT codes. A better measure of resource utilization is to use the primary and secondary ICD-9-CM and CPT codes because this approach accounts for severity of the episodes. In other words, such a procedure allows for a better risk adjustment and a better estimate of use and costs.

## **Statistical Methods**

Having implemented procedures for defining episodes of care, the authors proceed to the statistical analysis. In general, the analysis is simple, straightforward, and appropriate for the kinds of data employed in the study. The authors use two-tail tests of significance to account for possible results in which the direct access (or the physician referred) group is higher or lower in cost and use of services. Likewise, the transformation of visits and costs into a logarithm is a standard transformation used by health services researchers for these kinds of data.

In addition, the use of interaction terms in the equations (i.e., direct access-drugs, direct access-hospital, direct access-radiology) and the use of the drug, hospital, and radiology variables in the equations are attempts to control for severity of illness and its effect on use and cost. While these three variables and the interaction terms are not “perfect” measures of severity, their use is reasonable given the nature of the data. It would be preferable to have more direct and better measures of severity. However, such clinical-based data are usually not available in insurance claims files.

Finally, the most severe limitation of the analysis is not the statistical analysis and procedures *per se*. Rather, the limitations are in the nature of the use of claims data sets. Such data sets are not rich in terms of the number and kinds of variables that could give a better picture of factors that influence use and cost of services. As mentioned previously, we have no data on marital status, economic status, etc. These and other clinical and socioeconomic data are necessary to complete a full and appropriate analysis.

## Conclusions

Our general conclusion is that the study does not make a convincing argument that use and costs of services for direct access are lower than for physician referral services. In part, the algorithm and methods employed make it difficult to identify with any certainty, direct access patients. The preceding analysis results in some obvious conclusions, summarized below:

- (1) Based on a survey article in *Physical Therapy*, a significant percent of physical therapists do not support direct access;
- (2) Because the study is classified as “*exploratory*” research and not “*explanatory*” research, the conclusions should be viewed with caution.
- (3) Many of the assumptions supporting direct access cannot be proven scientifically, or they are unfounded;
- (4) The evaluation design, a non-experimental design, makes it difficult to conclude that the observed effects of lower cost and use of services under direct access are due to real difference in how services are accessed as opposed to competing explanations. Competing explanations for the observed differences include marital status, geographic differences in access, the limitations associated with using only one payer’s data, Blue Cross and Blue Shield, etc.
- (5) There are significant problems in the methodology of constructing episodes of care and the selection of the study population and that cause the results to be questioned and limits the generalizability of the findings;

Paid claims data are useful for some types of analyses. However, the limitation of the data sets with regard to demographic, socioeconomic, and clinical data, make it difficult to reach any definitive conclusions on differences between direct access and physician referral services.

## WHY SHOULD YOUR CONSTITUENTS HAVE DIRECT ACCESS TO A LICENSED PHYSICAL THERAPIST?



IT JUST MAKES SENSE



# APTA

American Physical Therapy Association  
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Alexandria, Virginia 22314-1488  
[www.apta.org](http://www.apta.org)

# Why Should Your Constituents Have Direct Access To A Licensed Physical Therapist?

## **Who Are Physical Therapists?**

Physical therapists are highly educated, licensed health care professionals who treat patients of all ages and varying health conditions. Most physical therapists hold a master's degree in physical therapy from an accredited professional education program, and all are required passing a strict state licensure examination before they may practice. Licensure and practice of physical therapy is regulated in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

Currently there are nearly 100,000 physical therapists practicing in the United States.

## **What Do Physical Therapists Do?**

Physical therapists examine, diagnose, and treat individuals with impairment, functional limitation, disability, or pain due to injury, disease, or other health-related condition. Treatment includes the consequences of disease or injury by addressing impairments, functional limitations, and/or disabilities in patients. Treatments used by physical therapists include therapeutic exercises, functional training, development and use of assistive devices and equipment, manual techniques (including mobilization and manipulation), airway clearance techniques, and electrical, physical, and mechanical modalities. Physical therapists also prevent impairment through establishing individual fitness and health programs.

Some of the conditions treated by physical therapists include, but are not limited to: Orthopedic conditions, such as low back pain, neck pain, headaches, and osteoporosis; Joint and soft-tissue injuries, such as fractures and dislocations, and pre- and post-surgical conditions; Neurologic conditions, such as stroke, traumatic brain injury, Parkinson's disease, cerebral palsy, and multiple sclerosis; Connective tissue conditions, such as burns, ulcers, and wounds; Arthritic conditions, such as osteoarthritis and rheumatoid arthritis; Cardiopulmonary and circulatory conditions, such as congestive heart failure and emphysema; Workplace injuries, such as carpal tunnel syndrome and stress disorders; and Sports injuries, such as overuse injuries and trauma in recreational and professional athletes.

## **Where Do Physical Therapists Practice?**

While many physical therapists practice in hospitals, more than 70% are in rehabilitation centers, private physical therapy practices, community health centers, the military, corporate or industrial health centers, sports facilities, research institutions, nursing homes, home health agencies, schools, pediatric centers, and colleges and universities.

## **What Is Direct Access?**

Direct Access is the right of an individual to obtain treatment from a licensed physical therapist where and when he or she may choose. In many states, a patient must first obtain a prescription or referral from a physician to receive the services of a licensed physical therapist.

## **Why Does Direct Access Make Sense?**

One of the most effective means of controlling health care costs is to allow a consumer to go directly to the health care provider who is best able to meet his or her needs.

It just makes sense. Direct access to a licensed physical therapist encourages preventive care, makes physical therapy services more accessible to more people, allows for an earlier return to work, and reduces the need for long-term care by providing early intervention.

## **Who Has Direct Access?**

In recognition that mandatory referral serves no constructive purpose, a majority of states and the U.S. Army have eliminated the referral requirement and have made physical therapy services directly accessible to the patient. And it works. In fact, the U.S. Army *has* “expanded” the physical therapist's role since the early 1970s, giving PTs the authority to refer patients for a variety of tests, to restrict patient activity and training when necessary, and to prescribe certain non-steroidal anti-inflammatory and analgesic medications. This “military model” of physical therapy was eventually deployed in some form by all of the other uniformed services - the U.S. Navy, the U.S. Air Force, and the U.S. Public Health Service.

## IT JUST MAKES SENSE!



### **Why Should You Support Direct Access Legislation?**

**Direct Access saves money for both consumers and insurers.** When a patient must go to a referring practitioner before visiting a physical therapist, that patient incurs a cost. This happens when the patient begins a physical therapy program and each time a patient needs to renew physical therapy treatment. Particular groups of patients, such as those with chronic or recurring conditions, bear the brunt of unnecessary referral costs.

A 1994 study on the cost-effectiveness of direct access to physical therapists found that the costs incurred for physical therapy visits were 123% higher when patients were first seen by a physician than when they went to a physical therapist directly. The total paid claims averaged \$2,236 for physician referral episodes as compared with \$1,004 for direct access episodes.'

**Direct Access does not promote over-utilization.** Liability claims and costs of liability insurance have not increased as a result of direct access to physical therapists. In fact, it was found that physician referral episodes generated 67% more physical therapy claims and 60% more office visits than did direct access episodes.'

**Direct Access maintains a high quality of care.** Knowledgeable in the musculoskeletal, neurological, pulmonary, and cardiovascular systems, physical therapists are highly educated health care professionals. Most practitioners hold a master's degree from an accredited physical therapy education program prior to state licensure. Through formal education and clinical experience, physical therapists are well qualified to evaluate a patient's condition, assess his or her physical therapy needs, and safely and effectively treat the patient.

**Direct Access encourages preventive health care.** Physical therapists educate patients on how to avoid injury or re-injury during activities of daily living and recreation. Knowing what to do to avoid injury helps patients help themselves. decreasing the number of visits to doctors' offices or emergency departments.

**Direct Access reduces the need for long-term care.** Waiting to see a physician before receiving physical therapy delays or prevents needed treatment and raises costs. By delaying or neglecting treatment, patients' medical conditions often worsen, forcing them and their insurers to pay much higher costs in long-term care.

**Direct Access makes physical therapy services more accessible to more people.** When traditional first-contact providers are in short supply in a given geographic area, and when access to physical therapy depends upon a referral from another practitioner, patients in need of physical therapy services may receive these services very late--or not at all.

1 Mitchell J, de Lissovoy G. A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy *Phys Ther.* 1997; 77:10-18.

## STATES AND NATIONAL ORGANIZATIONS ENDORSE DIRECT ACCESS

“Physical therapists are a vital part of the health care team. For many years, the citizens of Maryland have been fortunate - when they need physical therapy services, they have the same access to physical therapists as they do to other health care providers.”

Sen. Paula Hollinger (D-MD)

“The Oregon Legislature has always been concerned about the balance between consumer choice and patient protection in the healthcare arena. We are not interested in protecting any particular provider’s turf. Direct access to physical therapy services was an easy vote for me and most of my colleagues because it allows consumers to choose their type of practitioner while not jeopardizing their health.

Rep. George Eighmey (D-OR)

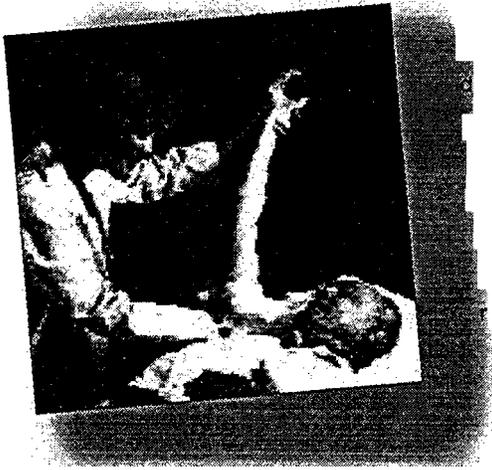
“Maginnis & Associates has been writing professional liability insurance coverage for physical therapists nationwide for over 25 years.... Our current insurance company and our major competitors do not charge a premium differential for physical therapists in Direct Access jurisdiction. As these companies review their rate structure on a regular and frequent basis, and because claims and premiums are so closely related to incidence of harm or injury to patients, we take this as a strong indication that Direct Access has had no material effect on the professional liability exposure.”

Maginnis & Associates

Providers of liability coverage for physical therapists

“NCSL supports policies that would allow direct, access to physical therapy and rehabilitative services, home health services, hospice services.... [Medicare] “NCSL supports efforts to provide more opportunities for states to use and develop alternative health care delivery systems.” [Medicaid]

National Conference of State Legislators (NCSL)



“The freedom of choice to see a physical therapist promptly can save you time and money and prevent delayed treatment of conditions that may prolong the recovery period. Having early and direct access to a professional trained in rehabilitative and preventive medical care can help ensure you a safer, speedier recovery.”

Sen. Sally Hopper (R-CO)

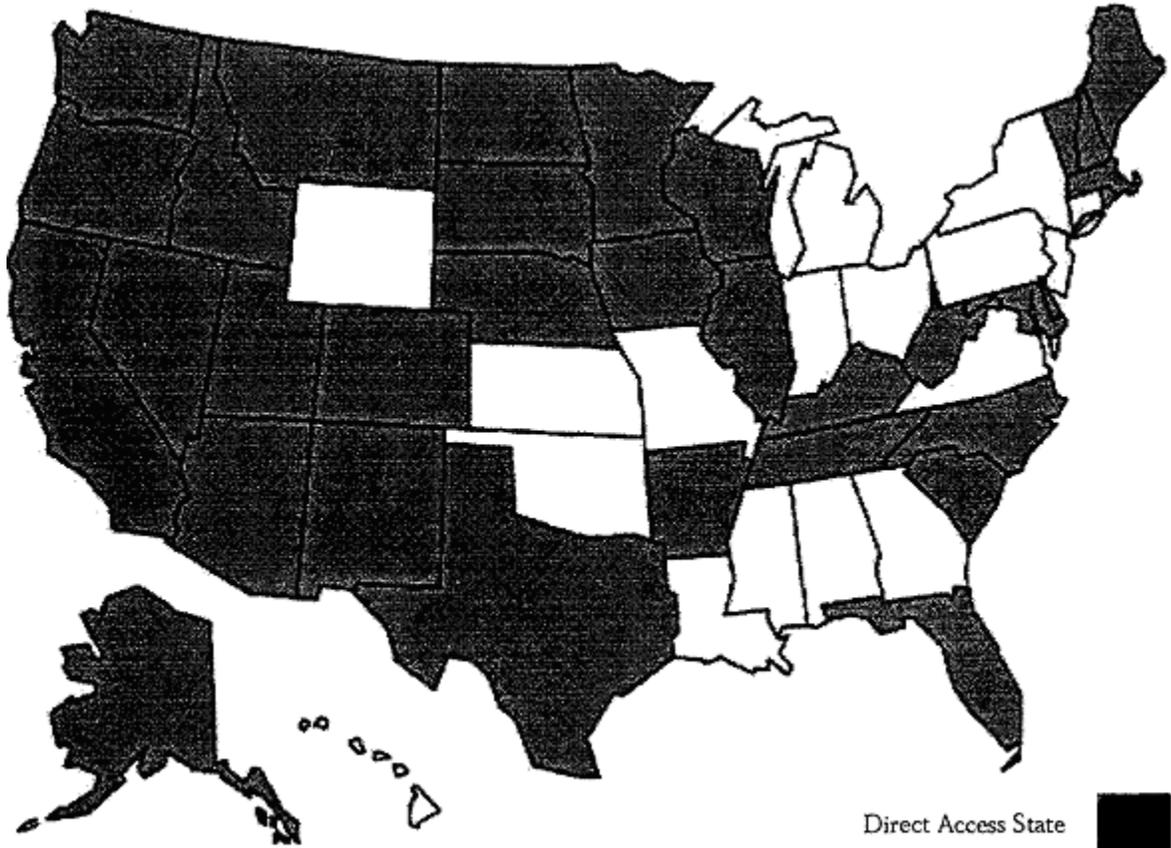
“The NBCSL urges the adoption of state legislation which permits access to physical therapists without, a physician referral.”

National Black Caucus Of State Legislators (NBCSL.)

“The requirement of consultation with an authorized health care practitioner prior to treatment by a physical therapist is a barrier to receipt of appropriate and timely care.... If there is a risk in removing mandatory consultation, it is no greater than the risk of using other licensed health care practitioners. Therefore, public health and safety are not compromised.... The cost impact may be decreased because the mandatory visit to another health care provider will be eliminated as a condition of access to a physical therapist.”

State Health Coordination Council Of Washington

## IS YOURS A DIRECT ACCESS STATE?



Alaska	1986	Maine	1991	Oregon	1993
Arizona	1983	Maryland	1979	Rhode Island	1992
Arkansas	1997	Massachusetts	1984	South Carolina	1998
California	1968	Minnesota	1988	South Dakota	1986
Colorado	1988	Montana	1987	Tennessee	1999
Delaware	1993	Nebraska	1957	Texas	1991
Florida	1992	Nevada	1985	Utah	1985
Idaho	1987	New Hampshire	1988	Vermont	1988
Illinois	1988	New Mexico	1989	Washington	1988
Iowa	1988	North Carolina	1985	West Virginia	1984
Kentucky	1987	North Dakota	1989	Wisconsin	1989
				Total = 33	

# WHAT YOU CAN DO TO SUPPORT DIRECT ACCESS

## If Your State Does Not Have Direct Access



- Sponsor or co-sponsor a bill to permit patients' direct access to physical therapists.
- If there is Direct Access legislation pending, it needs to be adopted.
- Include a provision for direct access to physical therapists as a cost-savings measure in any health reform bills.
- Visit a military installation and see direct access to physical therapists "in action." Create a demonstration project replicating the military model and watch the savings accrue.
- During efforts to streamline regulations or eliminate outdated statutes, consider elimination of the outdated physician referral requirement in physical therapy practice laws and rules.
- Consider eliminating barriers to physical therapy in Patients' Right To Choose bills.

## If Your State Has Direct Access

- Consider extending the cost savings of direct access to physical therapists to your state's Workers' Compensation program.
- Propose the use of Direct Access in your state's Medicaid program.

- Encourage your school systems to adopt direct access to a physical therapist for children with special needs.
- To maximize cost savings, support legislation that ensures reimbursement for all services within a health care provider's scope of practice.
- Request that your state insurance department let insurance companies know of the status of Direct Access in your state.

## A CASE IN POINT

Claire Elliot is a four-year-old girl with cerebral palsy. She is a charming youngster who attends the neighborhood nursery school program. She has been receiving physical therapy since she was about six months old.

Claire's family and her physical therapist have designed a treatment plan that incorporates therapeutic activities into her daily routines. When Claire shows significant changes in her progress, she receives intensive treatment from her physical therapist. Her therapy schedule changes to meet her specific needs. It is clear, however, that Claire will continue to need therapeutic intervention throughout her life.

Claire has begun to walk on her own. This is a time when intensive therapeutic intervention is warranted, and her family would like to begin physical therapy again.

However, Claire lives in a state where she must have a physician's referral before going back to the physical therapist. This has happened several times in the past and is extremely frustrating for Claire's mother, who must pay up to \$100 for each of these physician visits. Also, because Claire's condition is not an emergency, she must have an appointment and wait for a period of time before being able to see the physician. As a result, Claire loses precious therapy time at important transition stages in her functional skill development.

It has become extremely difficult and frustrating for Claire's mother to take time off work and to pay high physician fees so that Claire's therapy may be continued. She would like to see a time when her state would lift these unnecessary burdens and allow her and others like her to seek appropriate and cost-effective physical therapy services for their families and for themselves.

## COMMONLY ASKED QUESTIONS ABOUT DIRECT ACCESS

*Q. Will this legislation expand a physical therapist's scope of practice?*

**A. No.** Physical therapists are not asking to perform any additional procedures or to make a medical diagnosis. They are asking only to make decisions within the scope of physical therapy practice determined by education and experience.

*Q. What about the "straw man" argument that a physical therapist may miss a diagnosis of cancer, AIDS, or other life-threatening illness?*

**A. Physical therapists receive extensive education in evaluation and treatment. The physical therapy educational curriculum includes biology, chemistry, physics, anatomy, physiology, kinesiology, and neuroanatomy. Their academic preparation also includes recognizing symptoms and conditions that require evaluation by another health care professional before physical therapy is considered. Under Direct Access provisions, physical therapists will continue to work closely with physicians in deciding on a patient's treatment and goals even though a physician referral will not be mandated.**

*Q. Has Direct Access legislation resulted in any increase in a state's medical malpractice claims?*

**A. No.** There are no states in which Direct Access legislation has resulted in an increase in malpractice claims. According to [Aon Direct Group Inc.] the leading provider of professional liability coverage to the physical therapy profession, "We are aware that approximately 33 states allow patients direct access to physical therapists without a physician referral, and we monitor this legislation as it relates to program claims experience. To date, we have found no evidence that direct access has an impact on claims experience. While our analysis will be ongoing, we don't foresee a likelihood that direct access will become an issue to providers of professional liability coverage for the physical therapy profession."

*Q. Will this legislation lead to an increase in health care costs and an over-utilization of physical therapy services?*

**A. No.** Most insurers pay for physical therapy as a cost-effective means of treatment.

*Q. If Direct Access becomes law, will physical therapists abandon their hospital practices to become independent practitioners?*

**A. No.** According to APTA's 1996 Practice Profile Survey, the number of physical therapists in private practice has actually decreased from 27.4% in 1993 to 22.2% in 1996. There are 33 states that have Direct Access, and the number of physical therapists in private practice has gone down.

# STUDY SHOWS COST-EFFECTIVENESS OF DIRECT ACCESS

## **Cost-Effectiveness Of Direct Access To Physical Therapy**

*Jean Mitchell, PhD, Georgetown University, and  
Gregory de Lissoy, PhD, MPH, Johns Hopkins University, December 1994*

In a study conducted to determine whether direct access to physical therapy services provided by a licensed physical therapist is cost-effective, it was found that:

- The total paid claims for physician referral episodes to physical therapists was **123% or 2.2 times higher** than the paid claims for Direct Access episodes. The total paid claims averaged \$2,236 for “physician referral” episodes as compared to \$1,004 for Direct Access episodes. When expressed in terms of actual reimbursements, the difference in total paid claims per episode was \$1,232.
- Physician referral episodes were 65% longer in duration than Direct Access episodes.
- Physician referral episodes generated **67% more physical therapy claims** and **60% more office visits** than Direct Access episodes.

### **Background:**

Using health insurance claims data from Blue Cross-Blue Shield of Maryland, an expert panel of physicians and physical therapists analyzed 8,920 episodes of care from 3,000 individuals from 1989 through mid-1993. The authors concluded that, “Direct Access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes.”

*To obtain a copy of the study, please contact Janice Brannon, Associate Director of State Relations, APTA, 1111 North Fairfax Street, Alexandria, Virginia 22314-1488. Telephone (703) 706-3162.*