Approved: 3-13-01
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on February 19, 2001 in Room 231-N of the Capitol.

All members were present except: Senator Jordan (EA)

Committee staff present: Ms. Emalene Correll, Legislative Research Department
Ms. Renae Jefferies, Revisor of Statutes
Ms. Lisa Montgomery, Revisor of Statutes
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Ms. Susan Grace, President,
Kansas Physical Therapy Association
Mr. Paul Silovsky, Legislative Chair,
Kansas Physical Therapy Association
Ms. Evelyn Guzzo, State-Licensed Cosmetologist,
Instructor/Salon Owner, Student, Kansas Massage Institute
Ms. Patricia Bresnahan, Consumer
Ms. Karen Jorgensen, PTA, President National Assembly
Mr. Tom Bell, Sr, Vice President/Legal Counsel
Kansas Hospital Association
Mr. Blaine Miller, Republic City Hospital, Belville
Ms. Kimberly Templeton, M.D.
President of Kansas Orthopedic Society
Mr. Jerry Slaughter - Kansas Medical Society
Mr. Larry Buening, State Board of Healing Arts
Ms. Kathy Damron, American Message Therapy Assoc.
Ms. Judy Pope, Lobbyist for KS Chiropractic Association
Mr. Charles Wheelen, Executive Director
Kansas Association of Osteopathic Medicine
Ms. Paulette Danielson, RN, NCMT

Others attending: See Attached Guest List

Hearing on SB 187 - licensure of physical therapists

Upon calling the meeting to order, Chairperson Wagle announced that the Committee would be hearing a fair amount of testimony on **SB187** and asked each conferee to limit their testimony to three minutes. She introduced Ms. Susan Grace, President, Kansas Physical Therapy Association, as the first conferee to address the bill.

Ms. Grace presented proponent Testimony. A written copy of her testimony is (Attachment #1) attached hereto and incorporated into the Minutes by reference. Highlights of Ms. Grace's testimony included: licensure, definition of scope of practice, consumer access and initiation of physical therapy treatment.

The next proponent conferee was Mr. Paul Silovsky, Legislative Chair, Kansas Physical Therapy Association who defined the specific practice issues introduced by Ms. Grace and clarified the effects of these changes so that the Committee could compare both sides of the issues and their net effect on Kansas. A written copy of his testimony is (Attachment #2) attached hereto and incorporated into the Minutes by reference.

The next proponent conferee was Ms. Evelyn Guzzo, state-licensed cosmetologist, an instructor/salon owner/full time student at Kansas Massage Institute. She stated the current bill imposes undue restrictions for public access to those massage services that would not require diagnosis, treatment, or prescription as identified in the current bill for physical therapists. A copy of her testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference.

The last proponent conferee on the list was Ms. Patricia Bresnahan, Consumer, stating her disabilities from surgeries but that she benefitted from physical therapy. A copy of Ms. Bresnahan's testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference.

Written Proponent Testimony was also provided by Ms. Karen Jorgensen, PTA, President National Assembly stating that this bill accurately reflects the very basics of safe, quality patient care the National Assembly upholds for physical therapist assistants. A written copy of her testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference.

Opponent Testimony began with the introduction of Mr. Tom Bell, Sr. Vice President/Legal Counsel, Kansas Hospital Association, stating that there will always be instances where the hospital physical therapist is not immediately available, placing process ahead of patient care. A written copy of his testimony is (Attachment #6) attached hereto and incorporated into the Minutes by reference.

Mr. Blaine Miller, Republic City Hospital, Belville, was the next opponent conferee to come before the committee. Mr. Miller testified in behalf of the small community hospital A copy of his testimony and an opponent email from Ms. Lynette Nichol Withington, MSPT/ATC-R are (Attachment #7 and 8) attached hereto and incorporated into the Minutes by reference.

Ms. Kimberly Templeton, M.D., President of Kansas Orthopedic Society, was the next opponent conferee stating that optimal patient care requires that all members of the health care team work together, each being specifically trained to meet a specific need of each patient. A copy of her testimony is (Attachment #9) attached hereto and incorporated into the Minutes by reference.

Mr. Jerry Slaughter, Kansas Medical Society, was the next to give opponent testimony stating that the KMS concern is that physical therapists are not trained to make a medical diagnosis or use diagnostic tools such as x-rays. A copy of his testimony is (Attachment #10) attached hereto and incorporated into the Minutes by reference.

Mr. Larry Buening, State Board of Healing Arts, gave opponent testimony stating that a meeting was held on February 10, 2001 by the Board who reviewed the provisions and directed him to indicate to the Committee its opposition. A copy of his written testimony is (Attachment #11) attached hereto and incorporated into the Minutes by reference.

Ms. Coleen Mullen presented opponent testimony on behalf of the Kansas Chapter of the American Massage Therapy Association for Kathy Damron and Associates. Ms. Mullen gave a brief history of the AMTA and stating this bill would hurt the public by leaving persons seeking massage with no choice but to access the medical community. A copy of the written testimony is (Attachment #12) attached hereto and incorporated into the Minutes by reference.

Next on the opponent list was Ms. Judy Pope, Lobbyist for Kansas Chiropractic Association, who explained their concerns about authorizing physical therapists to perform manipulation based on three academic and ethical grounds. A copy of her written testimony and handouts are (Attachments #13) attached hereto and incorporated into the Minutes by reference.

Mr. Charles Wheelen, Executive Director, Kansas Association of Osteopathic Medicine, was the next opponent to testify stating they are not aware of any compelling evidence that licensing of physical therapists would improve quality of care. A copy of his written testimony is (Attachment #14) attached hereto and incorporated into the Minutes by reference.

The last opponent to testify before the committee was Ms. Paulette Danielson, RN, NCMT, covering her experience as a teacher of sports massage and massage therapy that takes a different approach from physical therapy. A copy of her written testimony is (Attachment #15) attached hereto and incorporated into the Minutes by reference.

Written Opponent Testimony was also provided by Ms .Lesa Roberts, Director, Health Occupations Credentialing, KDHE, that stated the bill was simply a move to license rather than register physical therapists without benefit of a credentialing review. A copy of her testimony is (Attachment #16) attached hereto and incorporated into the Minutes by reference.

Update of Kansas Credentialing Review Program Manual for Applicants

With all the testimony presented, Chairperson Wagle called on Ms. Marla Rhoden, Health Occupations Credentialing Program, Bureau of Health Facilities, Kansas Department of Health and Environment, who presented an update of the Kansas Credentialing Review Program, Manual for Applicants. A copy of her presentation and handout are (Attachment #17) attached hereto and incorporated into the Minutes by reference. A copy of the Manual is on file in the Chairperson's office.

The Chair then called the Committee's attention to an article regarding credentialing (65-5006) A copy of the article is filed in Chairperson Wagle's office.

The Committee then was able to present their questions to the conferees. Questions were asked by Senators Haley, Barnett, Harrington, and Salmans and responses from Mr. Silovsky, Ms. Pope, Ms. Grace, and Ms. Templeton ranging from misdiagnosis resulting in an increase in claims, bypassing primary care physicians for HMO, malpractice law suits, medical as opposed to muscular diagnoses to no increase in utilization, but decrease in utilization.

Adjournment

As it was 2:30 p.m., Chairperson Wagle thanked all of the conferees and adjourned the meeting.

The next meeting is scheduled for February 20, 2001.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday February 19

NAME	REPRESENTING
Chip Wheelen	Assoc. of Osteo. Med.
Kim Templeton, M.D.	KS Orthopedic Society
Dr. David Ross, M.D.	KAMMCO
Jerry Slaughter	KMS
Chris Collins	KMS
Judy Pope Edwards	KCA
Coleen Mullen	Kathy Damron + Assoc.
Rick Matthews	Health Midwest
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Tom Sloan PT	KPTA
Rio Baird, PT	KPTA
PHIL HORLEY	PAT HORLEY & CO.
Scott Hohmann	Kansas Physical Therapy Association
REDACTED	KS Occupational Therapy Assn.
GARY REDACTED	REDACTED
SUSAN Bechard	KPTA
Paulette Damilson	KMI
Evelyn Grupp	Rose Garden
Mark Dwyer	Kansas Physical Therapy Assoc.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Monday, Feb 10

NAME	REPRESENTING
Lesa Roberts	KDHE
Marla Rhoden	KDHE
Sheron Eaton	Massage Therapist
LARRY BUENING	BD OF HEALING ARTS
Carolyn Bloom	Ks Physical Therapy Assoc.
Larry Shaffer	Ks. Hosp Assoc
Tom Bell	KHA
Blaine E Nuller	Republic County Hospital
[illegible]	Ks Chiropractic Assn.

KANSAS PHYSICAL THERAPY ASSOCIATION

1200 SW 10th
P.O. Box 2428
Topeka, KS 66601-2428
Phone: (785) 233-5400
Fax: (785) 234-2433

Susan Grace, PT
President, Kansas Physical Therapy Association
1200 West 10th
P.O. Box 2428
Topeka, Kansas 66601

February 19, 2001

Chairman Wagle and Members of the Health and Welfare Committee:

I speak to you today as President of the Kansas Physical Therapy Association on SB 187 concerning physical therapy; relating to licensure, definition of scope of practice, consumer access, and initiation of physical therapy treatment. The physical therapy practice act has had minimal revision since its inception in 1963. Two revisions significant to this testimony were: the regulation of the physical therapist assistant in 1973 and an ammendment allowing physical therapist assistants to initiate treatment in 1991. Since the art and science of medicine has advanced tremendously since 1963 and the physical therapy profession has advanced in accord, we seek now to update the practice act in keeping with today's standards and practices. We are addressing the following areas:

Licensure

As defined by the Federation of State Boards of Physical Therapy, *licensure* implies the highest risk of potential harm to the public, a well defined scope of practice, an entry level competency examination, educational requirements and the ability of a state board to discipline the licensee if he/she doesn't meet the established legislative and regulatory standards. Physical therapists in Kansas meet all of the criteria listed above.

Additionally, in the "Model Practice Act for Physical Therapy," the Federation defines "physical therapy" as the care and services provided by or under the direction and supervision of a physical therapist *licensed* by the state. The American Physical Therapy Association (APTA) holds that, examination, evaluation, or intervention - unless provided by a physical therapist or under the direction and supervision of a physical therapist - *is not physical therapy,* nor should it be represented or reimbursed as such.

APTA
American Physical Therapy Association

Senate Public Health & Welfare Committee
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Attachment 1-1

The very foundation of a practice act centers on the concept that the public recognizes the *unique* training and qualifications of a given medical discipline and enacts laws governing their practice. When practitioners other than physical therapists represent that they are providing "physical therapy" they are violating the very spirit and core of licensure laws by misrepresentation to the public. Kansas Law defines "*licensure*" as a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful. In contrast, our state credentialing regulations define "*registration*" as the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

Physical therapists do, in fact, meet predetermined qualifications to practice. Physical therapy is a profession with an established theoretical base, widespread clinical applications and a defined body of knowledge. We have are bound by a "Professional Code of Ethics" and "Guide to Professional Conduct" and are directed by "Physical Therapy Standards of Practice." We have a defined scope of practice and must pass an entry level competency examination in order to be credentialed to practice. Physical therapy interventions require knowledge of both indications and contraindications as well as skill and judgement in application. Without such knowledge and expertise the potential for harm is significant.

Health care decisions are extremely complex for consumers today. Misinformation and misrepresentation can add to the confusion and place consumers at serious health and economic risk. Physical therapist "registration" does not protect the consumer from receiving care represented as physical therapy but administered by less qualified individuals. Physical therapist "registration" does not prevent the erroneous billing of those services. It is imperative that we present a true picture to the public. It is essential that we protect patient's right to physical therapy care provided by qualified practitioners and third party payer's rights to appropriate billing.

Scope of Practice

SB 187 is not intended to restrict persons licensed under any other law of this state from engaging in the profession or practice for which they are licensed. It does not change our scope of practice, it merely clarifies the language and brings it in line with nationally accepted standards and terminology.

Consumer Access

The original physical therapy practice act was adopted 1963 and has had not

Attachment 1-2

major revisions since. As you well know, since 1963, the practice of medicine and the healing arts has advanced dramatically in knowledge, sophistication and technology. The education, science and art of physical therapy has progressed in accord, as have our entry level educational requirements. We now require a Master's degree to enter the field.

Direct access to physical therapy services can benefit the consumer in a number of ways:

1. Increase consumer choice by providing an additional entry point into the health care system
2. Reduce health care costs by eliminating the expense of a physician office visit for referral to physical therapy services
3. Facilitate early intervention in neuromusculoskeletal disorders, decreasing the time from onset of symptoms to initiation of treatment thereby, improving treatment outcomes and decreasing recovery time and decreasing chronicity of symptoms
4. Promote prevention of neuromusculoskeletal disorders by allowing physical therapists to provide screening and public education to promote health and wellness
5. Facilitate intervention in school-based physical therapy programs
6. Promote intervention and injury prevention in industrial settings potentially reducing on the job injuries, absenteeism and lost wages due to on the job injuries.
7. Decrease length of treatment time by earlier intervention in disease process
8. Facilitate attraction of physical therapists and retention of new graduate physical therapist for employments in the state by allowing practice according to nationally accepted standards and norms

Initiation of Physical Therapy Treatment

The current statute allows for the physical therapist assistant to initiate treatment in a hospital setting when the physical therapist is not readily available, after telephone contact with the physical therapist. This provision contradicts the minimum requirements of the physical therapist in the statute (K.A.R. 100-29-12. Unprofessional conduct, 26 A-B) Further, this provision is in direct conflict with the American Physical Therapy Association's Code of Ethics, Standards of Practice and The Guide to Physical Therapist Practice. It conflicts with the Federation of State Boards of Physical Therapy's Model Practice Act.

This provision is **not** in the best interest of public safety. Physical therapist assistants are not educated or qualified to perform examination, evaluation, diagnosis or prognosis, the first four components of patient/client management

Attachment 1-3

which should be performed prior to intervention. Initiation of treatment prior to completion of steps one through four holds significant potential risk to the patient.

Kansas is the *only* state out of 50 that has this provision in the law. We seek to bring the Kansas statute into compliance with the standards of the physical therapy and healthcare community nationwide as well as protect the consumer.

I thank you for your consideration of SB 187 and ask that you support the proposed revisions to update the physical therapy practice act to reflect the current health care environment and standards of practice.

Respectfully submitted,

Susan Grace

Susan Grace, PT
President
Kansas Physical Therapy Association

Attachment 1-4

February 19,2001

Kansas Physical Therapy Association
1200 SW 10th Street
Topeka, Ks. 66604

Paul Silovsky, PT
Legislative Committee Chair
5220 SW 17th Street
Topeka, Ks. 66604

Chairman Wagle and Members of the Public Health and Welfare Committee:

As current Legislative Committee Chair, I represent the Kansas Physical Therapy Association in urging your support of SB 187, concerning the practice of Physical Therapy.

You are likely to hear testimony today with regard to various points of interest or concern over the modification of the current Kansas Physical Therapy Practice Act. I will define these specific practice issues and clarify the effects of these changes so that all of you may carefully compare both sides of the issues and their net effect on Kansans.

1. LICENSURE AND SCOPE OF PRACTICE: Within previous testimony and discussions over the subject of PT licensure and its scope of practice, the following points of concern have been presented by the groups that will testify today.

- The current "scope of practice" being too vague or broad. SB 187 more clearly defines the scope of practice as requested.
- Within previous testimony from the Kansas Chiropractic Association (KCA), while speaking in the opposition of Physical Therapy Licensure in 1999, the KCA clearly defined exactly why Kansans need Physical Therapy Licensure. The current Physical Therapy Act **"does not allow a physical therapist to do anything beyond what the general public can do. And it does not prohibit others form performing physical therapy treatment."**
- **SB 187, the Physical Therapy Licensure bill before you, has a complete list of exceptions that will allow all of those current providers who have overlapping scopes of practice with physical therapy to continue to practice as they are today.**
- With SB 187, we simply wish to protect the public from the harm that exists now and into the future when Physical Therapy services are not provided under the direction and supervision of a Physical Therapist.
- Manual therapy including soft tissue and joint mobilization and manipulation is listed within the scope of therapeutic interventions for SB 187. We are confident that there will be objections to this language even though these interventions have always been a part of Physical Therapy education, clinical training, and practice. **"Manipulation and mobilization have existed in physical therapy to some**

Senate Public Health & Welfare Committee
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Attachment 2-1

degree form the beginning" (Quote form Karl C Kranz, DC, Dept. of Research and Statistics, American Chiropractic Association) **" There is no evidence that physical therapists utilizing manipulative procedures produce a greater risk to the public's health."** (Karl Kranz, DC, Dept. of Research and Statistics, American Chiropractic Association)

- In February of 1996 the Kansas Office of the Attorney General issued a formal opinion that "chiropractic manual manipulation" is not within the scope of practice of medicine and surgery as defined by K.S.A. 65-2869. This opinion has since then been interpreted to mean that PT's could not perform chiropractic manual manipulation. First of all this is only an opinion on "chiropractic manual manipulation", which we do not perform. Secondly, there are most definitely varied definitions held for the word and conceptual understanding of the word manipulation within the texts of each of our professions.

2. PHYSICAL THERAPIST ASSISTANTS INITIATING TREATMENT: The Kansas Hospital Association will oppose this legislation as they intend for Physical Therapist Assistants (PTA's) to continue in their current capacity as an entry point for the initiation of Physical Therapy services in Kansas hospitals.

- Treatment delivered by a PTA is not Physical therapy unless a Physical Therapist has evaluated the patient and a care plan has been established.
- The PT and the hospital are falsely representing and misleading the public in thinking that they are receiving Physical Therapy by allowing the PTA to initiate treatment without prior evaluation, care planning, and proper informed patient consent to a plan of care that has been developed by the evaluating Physical Therapist in cooperation with the patient.
- **Under current practice standards the PT, PTA, and hospital are all on notice for creating increased liability by allowing the PTA to operate outside of their scope of education and training. This practice standard in in direct conflict with the regulations set forth by the Board of Healing Arts for "Unprofessional Conduct" (K.A.R. 100-29-12) and nationally accepted professional standards.**

3. CONSUMER ACCESS: You are likely to hear several groups testify against the right for the public to directly access the treatment services of a Physical Therapist. Listed below are just few of the reasons why the public should have the right to choose the health care provider who is best able to meet their Physical Therapy needs.

***From licensees who currently refer directly to Physical Therapists, we will hear that PT's can not and do not determine a medical diagnosis based upon lack of comparable training in differential medical diagnosis. To this I would respond that they are absolutely correct! However:**

1. Physical Therapists can and do currently evaluate patients without a physician referral, but without the primary purpose of determining a medical diagnosis. A PT is trained to render a diagnosis based upon the functional impairments of the patient. This is commonly referred to as a disablement model of care in The Guide to Physical Therapist Practice.

2. Physical Therapy treatment is delivered based upon those physical factors identified within the evaluation that that led the individual to their physical impairment or functional limitations.

Physical therapy professionals are asking to practice their already defined professional skills within their current scope of knowledge and training. We wish to update our practice act to reflect what we already deliver to the public we currently serve. Through SB187 we are asking to practice just as we are today while maintaining the professional responsibility that we have always upheld by not treating anyone outside of our defined scope of knowledge, training and expertise.

It has been repeatedly proven and well documented in states that do have direct consumer access to Physical Therapy treatment, that the cost of patient care has gone down and that the cost and incidence of professional liability has not risen. (Mitchell Study).

Thank you chairman Wagle and members of the committee. I would be happy to answer any questions you might have.

Paul Silovsky PT

Attachment 2-3

Monday, February 19, 2001

SENATE BILL No.187

Good afternoon everyone. I would like to thank you for giving me the opportunity to speak briefly regarding Senate Bill No.187.

My name is Evelyn Guzzo and I am a 52yr.old resident in Topeka. My professional training spans 35years. Currently I am a State Licensed Cosmetologist and Instructor, State Licensed salon owner, Certified Reflexologist and a program student attending the Kansas Massage Institute. I will be graduating this May with an A average, and will then take my exam to become a Nationally Certified Massage Therapist. I know the business world and have extensive experience working with the public, having spent 18 years as a Licensed Real Estate Broker, worked in mortgaging, and have 9yrs. experience as a Senior Sales Coordinator for several Fortune 500 /international electronics companies.

Undoubtedly, the most important facet of licensing is the protection of the public. For that reason, I am pro Senate Bill No. 187 **BUT ONLY** with several modifications. Protection of the public should supercede the promotion of any particular profession but, in my opinion, this bill as currently written would exclude the practice of massage therapy by appropriately trained massage therapists. Those without any proper training should be prohibited from providing massage therapy to the public. Suitable training should include knowledge of proper sanitation, knowledge of communicable diseases, anatomy & physiology, various massage modalities, and good business practices/ethics. Appropriately trained massage therapists receive such training and are able to pass a national exam recognized by over 25 states that currently license massage therapists. Even though Kansas does not yet license massage therapists, the services provided by massage therapists have been found to be beneficial to the public.

The current bill **imposes undue restrictions for public access to those massage services that would not require diagnosis, treatment, or prescription as identified in the current bill for Physical Therapists.**

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Evelyn Guzzo (2.)
Senate Bill No.187

As a massage therapist, I wish to offer to the public safe, alternative ways to relaxation and relief of stress. Persons who wish to seek out massage after a hard day at the office or working out at the health club should have the right to access this type of massage. Persons in nursing homes or that are homebound will also be able to reap many benefits, both physiologically and mentally from massage. If a person came to me with anything that was beyond my training expertise or questionable, I am trained and even required by my professional ethics to immediately refer that person to a medical practitioner. **The bill as currently written would not allow the public access to my training and services. This is not in the best interests of the public.**

Physical Therapists and Massage Therapist can co-exist, one complementing the other. Neither should try to replace the other for the need for both exists. We must stop unqualified persons from preying on our people. We need to concentrate on eliminating the unsavory element that plagues our profession and is a menace to our public. **I am in favor of providing a separate certification or licensing of massage therapists in the state of Kansas. Other states have done this successfully, and I am confident that Kansas possesses the power, through our Senators to do the right thing.** Until licensing of massage therapists becomes a reality, **I strongly request that Bill 187 be amended to specifically not restrict the provision of massage therapy by appropriately trained massage therapists who have passed the national exam recognized by over 25 states that currently license massage therapists.**

Thank you for your attention to this important issue and thank you for this opportunity to speak with you.

Attachment 3-2

Patricia Bresnahan
1810 Kendrick Lane
El Dorado, Kansas 67042

February 19, 2001

Senator Wagle and Members of the Health and Welfare Committee,

I am writing to ask for you support for SB 187 regarding increasing consumer access to physical therapy services. I am disabled due to Rheumatoid Arthritis which I have had for 33 years. I also have a limited income.

I have had a total hip replacement, two back surgeries and multiple hand surgeries. I have benefitted from physical therapy on each of those occasions. As my condition worsens and I experience more frequent acute episodes when I know therapy would help. In order to see my physical therapist, I have to wait for an appointment with my doctor and go through the trouble and expense of an office visit, only to get the referral I knew I needed in the first place. This procedure is often so cumbersome and expensive that it is prohibitive. If I could go directly to my therapist, it would save me a lot of suffering as well as expense and I would be more able to get the care that I need.

I also support licensure for physical therapist. I want to know that when I receive physical therapy, it is, in fact, from a physical therapist. I have undergone 'therapy' treatment before, thinking it was physical therapy and then discovered it was not. I derived little benefit from that treatment and was further appalled when I got bill. This is very misleading!

I ask you to support this bill so that me and people like me can get the treatment we need in an expedient and cost effective manner and that we know what we're getting when we get it!

Thank you for your consideration.

Respectfully Submitted,

Patricia Bresnahan

APTA
American Physical Therapy Association
National Assembly of Physical Therapist Assistants

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 706 8575 fax
www.apta.org

February 16, 2001

Senate Health and Welfare Committee

To: Senator Wagle
Members of the Senate Health and Welfare Committee

As President of the National Assembly of Physical Therapist Assistants (National Assembly), a component of the American Physical Therapy Association, I am writing this letter to support Senate Bill 187. The National Assembly represents physical therapist assistants within the profession and within the American Physical Therapy Association. As you know this bill seeks to define the physical therapists scope of practice and achieve licensure for the physical therapist. The bill also includes a provision to rescind the clause allowing physical therapist assistants the ability to initiate patient treatment under certain circumstances.

Numerous Association policies clearly identify the physical therapist as the professional that initiates patient care in all circumstances. It is beyond the scope of the physical therapist assistant and inappropriate for them to initiate patient care in any circumstance. While physical therapist assistant education includes comprehensive curriculum in the provision of physical therapy interventions to treat patients, it does not include teaching of the in depth skills needed to evaluate a patient and initiate physical therapy care. There is significant potential for harm to the patient when allowing a physical therapist assistant to initiate patient care.

Again I encourage you to support Senate Bill 187 as it accurately reflects the very basics of safe, quality patient care the National Assembly upholds for physical therapist assistants.

Sincerely,

Karen Jorgensen, PTA

Karen Jorgensen, PTA
President National Assembly

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 5-1

National Multiple Sclerosis Socie
South Central & Western Kansas Divisio
250 South Laura
Wichita, KS 67211

NATIONAL MULTIPLE SCLEROSIS SOCIETY

South Central &
Western Kansas Division

Tel 316-264-1333
1-800-FIGHT MS
Fax 316-264-5436
E-Mail: kss@nmss.org
www.nmss.org

February 16, 2001

David Sanderson RPT
Kansas Physical Therapy Association
Topeka, KS

Dear David:

The South Central & Western Kansas Division of the National MS Society is located in Wichita, Kansas. We cover 54 counties in south central & western Kansas. We provide services and programs to over 1,700 individuals with MS.

Many individuals with multiple sclerosis need and rely on physical therapy as part of their overall physical health and well being. Not only individuals with MS, but the general public as well, should be able to feel confident about going into physical therapist and knowing that this person has been fully trained from an accredited PT school and has passed a state examination to perform physical therapy.

I can't believe that in our great state of Kansas, there are individuals that can practice without a license. We need stronger regulations for this to insure that the general public receives the best educated and qualified PT professionals serving them.

Sincerely,

Kelly Rawlings

Kelly Rawlings
Division Manager

Attachment 5-2

Main Identity

From: "Robert Manske" <manske@chp.twsu.edu>
To: <aclaycamp@epiphanyworks.com>
Sent: Friday, February 16, 2001 3:23 PM
Subject: PTA's initiating Treatment

To whom it may concern,

I do not feel that it is any longer necessary to allow PTA's to initiate treatment, even in a rural setting. PTA's do not have the evaluation skills necessary to determine a treatment upon an initial evaluation. Even with having a phone conversation with a therapist, I think this is inappropriate. This law as I understand was enacted when there was a incredible demand for PT's and PTA's. As I understand it that is no longer the case. Regardless of wether that is the case of not, I do not feel that it is an appropriate means of care for those in rural towns. It would be in our and our patients best interest to allow an actual registered therapist perform the evaluation and initial treatment.

Thank you for your time,

Sincerely,

Robert C. Manske, MEd, MPT, ATC, CSCS

Attachment 5-3

2/16/01

Main Identity

From: "Meri Goehring" <goehring@chp.twsu.edu>
To: <aclaycamp@epiphanyworks.com>
Sent: Friday, February 16, 2001 3:13 PM
Subject: PTA's initiating treatment in a hospital setting

Dear Amy,

On the topic of PTA's being able to initiate treatment in a hospital setting, I would like to state my objections to this practice. In my role as a PT and as an instructor of PTA's I know that therapist assistants are well trained and capable. That is not the issue. The issue is that this practice weakens our ability as PT's to promote and practice the appropriate, standardized level of supervision of PTA's. A PTA should not be allowed to initiate treatment unless a PT has performed an evaluation regardless of the setting.

Please let me know if I need to forward this to any other individuals. Thanks!

Meri Goehring, PT, MHS, GCS
Department of Physical Therapy
Physical Therapist Assistant Program
Wichita State University
1845 Fairmount
Wichita, KS 67260-0043
316-978-3604
FAX: 316-978-3025
E mail: goehring@chp.twsu.edu

Attachment 5-4 2/16/01

February 19, 2001

To the Senate Health Committee:

I am writing in support of SB187. I am a physical therapist and the director of a rehabilitation department in a general acute hospital. If the provision that allows the physical therapist assistants to initiate physical therapy after a verbal contact with a PT was eliminated, it would not impact our department at all. We never have the assistants initiate treatment prior to the physical therapist's evaluation. Medicare does not pay for treatment given prior to the evaluation, the physical therapist assistants are not trained to evaluate patients and most do not want to see patients prior to the evaluation. I have never supported this provision of our practice act. As a former member of the Physical Therapy Examining Committee, I oppose assistants being allowed to initiate treatment prior to the PT evaluation. It is a good way for unscrupulous practitioners and hospital administrators to provide less than quality patient care.

Jackie Rawlings
700 Gillespie Drive
Manhattan, Kansas 66502

Attachment 5-5

Main Identity

From: "Terry Jett" <pthiker@kc.rr.com>
To: <aclaycamp@epiphanyworks.com>
Sent: Sunday, February 18, 2001 9:59 PM
Subject: Support of Legislative Alert

I am writing in support of KPTA's legislative efforts to eliminate the PTA initiation of Physical Therapy Treatment.
I have been a practicing PT since 1981. Ever since then I have not been in support of any PTA initiating treatment without first being evaluated by a PT. Simply put, not only do I value my professional license and knowledge but I also value and want to support the PTA who I am supervising in the clinic. I have worked with some very excellent PTA's in my career but I also know that in their clinical academia the level of education they receive does not provide them with the clinical reasoning skills to make informed decision that are required during an evaluation by a PT.
In our efforts to advance our practice act to Consumer Access with our profession, we must be able to demonstrate our advanced knowledge and skills are required to initiate treatment appropriate for the patient presenting to us. With this effort comes the clinical reasoning skills that are learned in the clinical and classroom academia which advances PT's to the level of either Masters or PhD's and provides us with the advanced knowledge to practice autonomously without a physicians referral. We must be able to demonstrate this level of education and advancement and by letting PTA's continue with this practice we are devaluing our services and skills not only to our patients but to our payers and constituents.
As a hospitals reimbursements are being reduced, it is imperative that we demonstrate our value and medical knowledge as payers are focusing their payments on the particular clinician delivering the service. I truly believe that payers want to see the more experienced and educated clinician treating and billing for the skilled level of service provided, and to avoid further reimbursement cuts to our profession, we must demonstrate that outcomes can and will be enhanced by a thorough and complete evaluation performed by a PT from the onset of treatment. Not only do we as a profession want to see denials for our services lessened but I know so does the hospital organization some of us work for.
We must continue to focus and support evidence based outcomes and in order for us to do this we need a strong and well documented evaluation performed first to establish a constructive plan of care to direct the PTA in treatment. Days missed before the PT can establish a POC could potentially add to the length of stay and diminished functional outcomes.
I don't want to sound like I don't support PTA's for I do, just not in the case of initiating treatment without the patient first being seen by a PT.

Thank you for this opportunity.

Terry Jett, MBA,PT

Attachment 5-6 2/19/01

Main Identity

From: "Durst Family" <durstfam@midusa.net>
To: <aclaycamp@epiphanyworks.com>
Sent: Sunday, February 18, 2001 9:45 PM
Subject: PTA initiating treatment

I am very much in favor of correcting the Kansas Physical Therapy Practice Act to not allowing a Physical Therapy Assistant to initiate teatment prior to an evaluation by a Physical Therapist.

Currently, Kansas is the only state that allows this to take place. This exception was done many years ago as a way around a perceived shortage of Physical Therapists. It should not have been allowed then and certainly has no benefit to patients now with plenty of PTs available.

CPTAs are not trained to treat a patient without a treament plan by a Physical Therapist. This is forbidden by standards of practice of the American Physical Therapy Association, the Federation of State Boards of Physical Therapy, and published Guide to Physical Therapist Practice.

Les Durst PT SCS
2042 Raymond Ave.
Salina, Ks 67401
785-825-5560

Attachment 5-7

Main Identity

From: "Daryl Menke" <daryl@cjnetworks.com>
To: <aclaycamp@epiphanyworks.com>
Sent: Friday, February 16, 2001 8:22 PM
Subject: SB 187 - PTA provision

My name is Daryl Menke, I am a Physical Therapist in Topeka, Kansas.

I support the provision of prohibiting the PTA's ability to initiate treatment prior to or without a Physical Therapist first assessing the patient and developing the treatment plan.

1. The current Kansas Practice Act clearly delineates that a patient must first be seen and assessed by a *Physical Therapist,* and a plan of care established. The Physical Therapist may then delegate certain treatment aspects to the Physical Therapist Assistant. Therefore we are not adding anything new, we are simply enforcing the current statue.
2. This stance is consistent with the APTA and all other state associations. Refer to the Code of Ethics, Standards of Practice, Guide to PT and PTA Standards, the HOD, and The Practice Guide.
3. Medicare and Medicaid rules and regulations are specific in the fact that a *Physical Therapist* must initiate and assess the patient and develop the plan of care prior to delegation of certain treatment aspects.
4. Most if not all other third party payers also utilize this standard. In fact, and unfortunately, there is a trend with third party payers that will not allow any interventions by the Physical Therapist Assistant.
5. The argument that the rural areas would be faced with a shortfall or delay in initiation of treatment is false, and based on economics. The old argument that there is an insufficient number of Physical Therapists for coverage in the rural areas is also a fallacy.
6. A review of hospital regulatory agencies such as JCAHO, CORF, etc. would also reveal that the standard of practice is the *Physical Therapist* must initiate and assess the patient and develop the plan of care prior to delegation of certain treatment aspects.
7. A review of hospital bylaws, rules and regulations, and policies and procedures would further substantiate the fact the *Physical Therapist* must initiate and assess the patient and develop the plan of care prior to delegation of certain treatment aspects.
8. The current educational system also standardizes the fact that the *Physical Therapist* must initiate and assess the patient and develop the plan of care prior to delegation of certain treatment aspects.

Sincerely,

Daryl Menke PT
(785) 478 - 4758
(785) 271 - 5533
daryl@cjnetworks.com

Attachment 5-8

2/19/01

Memorandum

Donald A. Wilson
President

To: Senate Public Health and Welfare Committee

From: Kansas Hospital Association
Thomas L. Bell, Sr. Vice President/Legal Counsel

Re: **Senate Bill 187**

Date: February 19, 2001

The Kansas Hospital Association appreciates the opportunity to comment regarding Senate Bill 187, which would: (1) grant licensure status to physical therapists; (2) create "direct access" to physical therapists; and (3) remove language in current law allowing for early initiation of physical therapy services. We are opposed to this bill as written.

The Kansas law says that credentialing by the state is only appropriate when the following findings are made:

1. The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public, and the potential for such harm is recognizable and not remote.
2. The practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, and the public will benefit by regulation of this area.
3. If the practice is performed under the direction of other health care personnel or inpatient facilities providing health care services, such arrangement is not adequate to protect the public from persons performing non-credentialed procedures.
4. The public is not adequately protected from harm by means other than credentialing.
5. The effect of credentialing on the cost of health care is minimal.
6. The effect of credentialing on the availability of health care personnel is minimal.
7. The scope of practice is identifiable.
8. The effect of credentialing on the scope of practice of other health care personnel is minimal.
9. Identifiable national standards of education or training exist for the occupation.

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 785/233-6955 • www.kha-net.org

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 6

This law was passed to provide the legislature with guidance and criteria when professional groups seek to be credentialed. It provides a mechanism for such groups to go through a process where a "technical committee" initially reviews the application. This technical committee reviews the nine criteria and applies them to the case at hand, providing legislators with guidance regarding difficult clinical issues. In the case of SB 187, that process has not been followed.

Current law states that in a hospital setting where the physical therapist is not immediately available, the physical therapist assistant may begin patient care after telephone contact with the physical therapist pursuant to specific instructions from the physical therapist. The physical therapist must then see and evaluate the patient as soon as possible with a minimum weekly review thereafter. SB 187 proposes to remove this language at page 9, lines 42-43, and page 10, lines 1-4.

The Kansas Physical Therapy Association originally agreed to the language in question as a way to provide better access to care in rural parts of the state during a time when there was a severe shortage of physical therapists. While the shortage of physical therapists has eased somewhat in urban settings, there remains a significant shortage in many rural areas. We think this part of the law is still important. No matter how many physical therapists there are in Kansas, some small hospitals will simply not have the need or the resources to have a full-time physical therapist. Because of this, there will always be instances where the hospital physical therapist is not immediately available. In such instances, the current law allows physical therapy to begin right away, while the proposed amendment would make the patient wait until the physical therapist personally sees the patient. The proposed amendment would place process ahead of patient care.

Thank you for your consideration of our comments.

Attachment 6-2

REPUBLIC COUNTY HOSPITAL
2420 G Street ◆ Belleville, Kansas 66935-2400 ◆ 785-527-2254
www.RepublicCountyHospital.org

To: Senate Public Health and Welfare Committee

From: Blaine Miller
Administrator
Republic County Hospital

Re: Senate Bill 187

Date: February 19, 2001

Thank you for the opportunity to comment regarding the provisions of SB 187, which creates numerous changes in the physical therapy law. My name is Blaine Miller and I am the administrator of the Republic County Hospital in Belleville. Belleville is a community of 2,500 persons, many of which are over the age of 65. Our hospital is licensed for 48 acute and 38 long term care beds and can be typified as a larger, small rural hospital that provides health care services to a high percentage of Medicare aged patients.

I am testifying today in opposition to SB 187 on behalf of our community hospital and also the Kansas Hospital Association. There are several troublesome issues raised by this bill, such as whether it bypasses the statutory credentialing process. However, those issues will be covered by other conferees. I would like to use my time to focus on one specific patient care problem created by Senate Bill 187.

Current law states that in a hospital setting where the physical therapist is not immediately available, the physical therapist assistant may begin patient care after telephone contact with the physical therapist pursuant to specific instructions from the physical therapist. The physical therapist must then see and evaluate the patient as soon as possible with a minimum weekly review thereafter. SB 187 proposes to remove this language at page 9, lines 42-43, and page 10, lines 1-4.

The Kansas Physical Therapy Association originally agreed to the language in question as a way to provide better access to care in rural parts of the state during a time when there was a severe shortage of Physical Therapists. While the shortage of physical therapists has eased somewhat in urban settings, there remains a significant shortage in many rural areas. We think this part of the law is still important for several reasons. First, no matter how many physical therapists there are in Kansas, some small hospitals will simply not have the need or the resources to have a full-time physical therapist. Because of this, there will always be instances where the hospital physical therapist is not immediately available. In such instances, the current law allows physical therapy to

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begin right away, while the proposed amendment would make the patient wait until the physical therapist personally sees the patient.

Second, current law does not give physical therapist assistants the discretion to begin treatment on their own. Nothing can happen until the physical therapist has considered the patient's condition and approved the initiation of treatment. Adopting the proposed amendment would actually remove some of the physical therapist's discretion by prohibiting one method of initiating treatment.

Finally, it is important to note that, in our opinion, this issue is totally about patient care. Medicare rules state that hospitals do not get paid for physical therapy services provided to Medicare patients until the physical therapist has actually seen the patient. Therefore, any treatment initiated by the physical therapist assistant prior to personal evaluation by the physical therapist is not reimbursed. In such cases, *the sole reason to begin physical therapy after phone consultation between the physical therapist and the assistant is to take better care of the patient.* I am personally aware of many hospitals that have physical therapist services available only two to three times per week. Without this provision, needed patient care would be delayed or patients would be required to travel considerable distances for physical therapy services.

We urge you to reject this amendment and allow the current law, which has served a valid purpose, to remain. Thank you for your consideration of our comments.

Attachment 7-2

From: kochs@grisell.hpmin.com
Sent: Friday, February 16, 2001 4:51 PM
To: wagle@senate.state.ks.us; tbell@kha-net.org
Subject: Senate Bill 187

To: Honorary Chairwoman Wagle and Senators of Health and Welfare Committee

I am writing this letter to oppose the third portion of Senate Bill 187 regarding the ability of physical therapy assistants to contact their physical therapist by phone prior to initiating treatment in a hospital situation. This is being done on the behalf of the small rural hospitals who, because of financial costs and patient volume, ban together to contract physical therapists to provide services to compliment certified physical therapy assistants.

I am a member of both the Kansas Physical Therapy Association and the American Physical Therapy Association, but do not feel that these organizations always allow for the needs of the small rural hospitals.

Patients from small communities are presently served by a combined effort of physical therapists and physical therapist assistants which allows them to return to their home town enviroment. This not only lessens the burden on family members, but also provides friends with the opportunity to visit the patient more readily. These factors, as well as receiving treatment from home town health care providers, help expediate the patient's recovery.

Physical therapy assistants in rural communities are also able to provide quality care to patients in a different capacity than their urban counterparts. CPTA'S in rural hospitals are very autonomous and often do the managerial work of a P.T. department as well as providing excellent patient care. The physical therapist in these settings have close relationships with the physical therapy assistants for which they provide supervision. Their level of competency and ability to provide quality care is of the utmost concern to the physical therapist. The CPTA's which I personally supervise now and have had the privilege of supervising at previous facilities in which I have worked, are excellent regarding both.

I am also aware that the Kansas Physical Therapy Association has been made aware of our concern regarding this issue at some of the town meetings at which both physical therapist and physical therapy assistants have spoken.

The issue at hand is not because of a shortage of physical therapists at

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Attachment 8-1

t. time. We are very acutely aware of the changes in availability of therapists in the recent years. The issue does exist because of the economic status of the rural communities who have not necessarily enjoyed the healthy economy of the recent past. Small hospitals simply cannot afford full time physical therapists. They feel a loyalty to their physical therapy assistants who have served their hospitals well.

I am also aware that Kansas may be the only state in the Union who provides treatment with these allocations, but feel that it has served the needs of our patients in a fair, appropriate, and timely manner.

I urge you to take into account the thoughts and needs of rural Kansas and the patients who receive services here when discussing this issue. Thank you for your consideration.

Sincerely

Lynnette Nichol Withington MSPT/ATC-R

Attachment 8-2

SB 187 Physical Therapy
Kimberly J. Templeton, MD

Optimal patient care requires that all members of the health care team work together. Each member of the team is specifically trained to meet a specific need of each patient. SB187 would allow physical therapists to treat patients without a prior physician assessment or referral. Physical therapists are excellently trained to work with patients with various neurologic and musculoskeletal conditions and are a critical part of the health care team. However, they are not trained in the diagnosis of these conditions. More specifically, their education focuses in on these particular disease processes and does not give them the background in other areas. While physicians spend 4 years in medical school and an additional 3-7 years in residency training with a potential for another 1-2 years in fellowship training, a typical physical therapy curriculum contains 2 semesters on a "survey of medical sciences". This is inadequate to allow them to learn the spectrum of disease processes that may manifest as musculoskeletal conditions. The bill states that they do not wish to practice medicine, yet arriving at an accurate diagnosis is the cornerstone of medical treatment. Further, they are not allowed to interpret x-rays, yet this is a primary diagnostic modality for some, especially refractory, musculoskeletal conditions. Physical therapists are not educated in pharmacology and are not allowed to prescribe medicine. This denies their patients an important avenue of treatment. Some conditions may be alleviated with medication, eliminating the need for physical therapy.

The argument from the therapists is that direct access would be more cost effective. However, the single study to address this, by Mitchell and Lissovoy, has many flaws. There is no discussion of patient outcome. Any difference in cost could be related to severity of illness or patient background. There is no discussion on how similar the patient groups are.

Each member of the health care team fulfills a specific role. Physical therapists are a vital component of this team and are well-qualified to "determine the plan of therapeutic intervention". However, the physician members of the team are trained at arriving at the diagnosis and, potentially, prescribing additional or other treatments. Patient safety and the overall health of our community are at risk with this proposal.

KMS
KANSAS MEDICAL SOCIETY

To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Date: February 19, 2001

Subject: SB 187; concerning physical therapy

The Kansas Medical Society appreciates the opportunity to appear today in opposition to SB 187, which significantly amends the physical therapy practice act. This legislation does the following: 1) it eliminates the requirement for PT consultation with a physician prior to beginning treatment (so-called "direct access"); 2) it changes the credentialing status of PTs from registration to licensure; 3) it substantially amends the PT scope of practice definition; and 4) in the hospital setting, it eliminates the authority for physical therapy assistants to initiate treatment prior to the patient being seen by a PT.

Let me make it clear that we value the important role physical therapists play in the health care team. The team approach that is in place today for treating diseases and conditions of the musculoskeletal system works well for patients. It ensures that a medical diagnosis is made of the patient's condition prior to the initiation of any treatment. Under current law, a physical therapist may only begin treatment after a physician has been consulted. This protects the patient by assuring that their care is based on a medical diagnosis and that physical therapy is the right treatment given at the right time. SB 187 would eliminate the requirement that a PT consult with a physician prior to beginning treatment.

Our concern with this change is that physical therapists are not trained to make a medical diagnosis. PTs also do not use nor interpret diagnostic tools such as x-rays and laboratory tests, which are often an essential component of evaluating a patient's problem and arriving at a diagnosis. Many musculoskeletal complaints such as back pain can be related to serious underlying diseases. For example, malignancies which spread to the spinal column; kidney tumors and other kidney disease commonly mimic as back pain; and abdominal problems involving the pancreas can cause back pain. If treatment is begun without a physician evaluation, the assumption is made that the patient has a simple strain or muscular injury, and valuable time can be lost before the patient is finally evaluated by a physician, possibly weeks later when the patient's condition does not improve.

While the bill significantly amends the PT scope of practice by almost doubling current language by adding new terms, it still does not - quite appropriately - include making a medical diagnosis. The result is that the bill ignores the fundamental medical principle of making a diagnosis prior to the beginning of treatment. It assumes that all pain and other problems can be treated by physical therapy, and that patients can accurately self-diagnose their problems.

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Meeting Date February 19, 2001
Attachment 10

The current system - the health care team approach - works well for patients. Physicians are consulted first so that underlying diseases and conditions can be ruled out before the PT initiates treatment. This collaborative arrangement protects patients and promotes quality care. SB 187 weakens the link between physician and physical therapist, which is not a positive step for promoting quality patient care. We urge you to report the bill unfavorably. Thank you for considering our comments.

Attachment 10-2

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413
FAX # (785) 296-0852
(785) 368-7102

MEMORANDUM

TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 19, 2001

RE: **S.B. No. 187**

Madam Chair and members of the Committee, thank you for allowing me the opportunity to appear before you on behalf of the State Board of Healing Arts regarding S.B. No. 187. At its meeting conducted on February 10, 2001, the Board reviewed the provisions of S.B. No. 187 and directed me to indicate to you its opposition to this bill.

Since this is my first appearance before you this session and there are several members who have not previously served on this Committee, I would like to provide a very brief description of the State Board of Healing Arts. The Board was created by the 1957 Legislature to regulate what became known as the three branches of the healing arts—medicine and surgery, osteopathic medicine and surgery, and chiropractic. Prior to that time, these three professions had been regulated by three independent boards. Since 1957, the Board has been given eight additional professions to regulate. The individuals in these professions are podiatrists, physical therapists, physical therapist assistants, physician assistants, respiratory therapists, occupational therapists, occupational therapy assistants and athletic trainers. The Board currently regulates in excess of 16,500 individuals in these 11 professions.

From 1957 until March 1, 2000, the Board licensed only individuals who qualified to use the terms "Doctor" in the health care setting. In 1975, by Executive Reorganization Order No. 8 issued by the Governor, the State Podiatry Board of Examiners was abolished and the powers, duties and functions transferred to the State Board of Healing Arts. Podiatric doctors, like M.D.s, D.O.s and D.C.s, were licensed by the Board. Each of these four licensed professions are able to independently examine, diagnose and treat patients without the intervention or supervision of any other health care professional. On the other hand, the other seven professions regulated by the Board were, at least until March 1, 2000, not licensed. Thus, there was a two-tiered credentialing system created by the Legislature, differentiating independent practice, i.e. licensure, from dependent practice, i.e. registration or certification.

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Attachment 1-1

The 1999 Legislature enacted a law that became effective March 1, 2000, changing the credentialing status of respiratory therapists from that of registration to licensure. Subsequently, the 2000 Legislature took action to change the credentialing of physician assistants from registration to licensure which just became effective February 1, 2001. Although the Legislature did change the level of credentialing for these two professions, their status as dependent practitioners was not changed.

K.S.A. 2000 Supp. 65-5502 (b) provides that " 'Respiratory Therapy' is a health care profession whose therapists practice under the supervision of a qualified medical director and with the prescription of a licensed physician". K.S.A. 2000 Supp. 65-28a02 states that " 'Physician assistant' means a person who is licensed in accordance with the provisions of K.S.A. 2000 Supp. 65-28a04 and amendments thereto and who provides patient services under the direction and supervision of a responsible physician". (Emphasis supplied).

S.B. No. 187 makes four major changes to the current statutes regulating physical therapists and physical therapist assistants. In Section 1, the current definition of physical therapy is deleted and replaced with a new and greatly expanded definition. The second change is that the credentialing level for physical therapists is converted from registration to licensure. Thirdly, all reference to the requirement that a physician refer a patient before treatment is initiated by a physical therapist has been deleted. Finally, section 10(c) of the bill deletes the ability of a physical therapist assistant to initiate patient care after telephone contact with a physical therapist in a hospital setting when a physical therapist is not immediately available. All of these changes substantially impact the manner in which physical therapists provide health care services.

The new definition of physical therapy in section 1 includes the making of a physical therapy diagnosis, manual therapy including soft tissue and joint mobilization and manipulation, therapeutic massage, alleviating impairments and promotion and maintenance of fitness, and health. Many of the specific procedures included within the definition of physical therapy clearly include procedures performed by other health care professionals. Respiratory therapists obviously perform airway clearance techniques and occupational therapy assistants clearly work to alleviate functional limitations. Yet, neither of these two professions are included in the list of individuals not construed to be engaged in the practice of physical therapy listed in section 10(c). Similarly, many people are engaged in the promotion and maintenance of fitness and health. Trainers in fitness centers are just some of these. One could even argue that by issuing a proclamation the Governor is engaged in the promotion of health and fitness. Yet, neither the Governor nor fitness center trainers are credentialed by an agency of the state of Kansas.

By changing the credentialing status of physical therapists from registration to licensure, this bill also creates a scope of practice for physical therapists. Therefore, unless specifically excepted, no person can perform what would amount to physical therapy unless the person is licensed as a physical therapist. For example, since massage therapists are not currently credentialed by the state of Kansas and are not included in the exceptions listed in section 10(c), this bill would prohibit these individuals from engaging in massage therapy as an occupation. Patient supply companies commonly adapt orthotic and prosthetic devices to meet the individuals needs of a person. However, these companies would be prohibited from performing these services under this bill.

Attachment 11-2

The third major change is that physical therapists will become independent health care providers. No longer will they be part of a doctor-directed health care team. Rather, they will be able to diagnose patients and initiate treatment without any involvement by a doctor. Yet, under section 1(d), physical therapists will not be allowed to use roentgen rays (x-rays) for diagnostic purposes. This is an extremely valuable and necessary tool prior to performing any joint mobilization and manipulation which are allowed under the definition of physical therapy.

The final major change is the amendment to K.S.A. 65-2914 on pages 9 and 10 of the bill. 1999 Senate Bill No. 192 proposed the same changes to this statute. When this committee considered that bill, a number of rural hospitals expressed concern that there could be delays in treatment of those patients who need physical therapy. These concerns were not alleviated by the suggestion that an adequate number of physical therapists are available because of changes made in health care reimbursement.

The State Board of Healing Arts is well aware of the contributions physical therapists make to the health and well being of citizens of this state. However, the Board believes that the changes made by S.B. No. 187 will have an adverse impact on the health and welfare of our citizens. I would be happy to respond to any questions.

Attachment 11-3

Kathy
Damron

(785) 235-2525
(785) 354-8092 FAX

1100 Mercantile Bank Tower
800 SW Jackson Street

Topeka, Kansas 66612-2205

Testimony on behalf of the
Kansas Chapter of the American Massage Therapy Association
Presented by Coleen Mullen for Kathy Damron and Associates
February 19, 2001

Madam Chair and Members of the Senate Public Health and Welfare Committee

I am Coleen Mullen, testifying before you in opposition to SB 187 on behalf of the Kansas Chapter of the American Massage Therapy Association (AMTA).

The Association has nearly 200 active members in Kansas and serves as an affiliate of the national organization. The AMTA is the largest professional organization of massage therapists in the nation.

The Kansas members are strongly opposed to SB 187, as they believe it would entitle only physical therapists and the medical community to practice massage therapy. The course of action envisioned in this bill, is a radical departure from current law and would have far reaching consequences for persons who practice massage therapy.

The proposed legislation would hurt the public by leaving persons seeking massage with no choice but to access the medical community. The limit of choice, added cost and inconvenience to the public are very real problems resulting from this bill.

The impact upon Kansas massage therapists would be devastating. Most, if not all, would be put out of business if SB 187 were to become law.

For those reasons, we respectfully seek your opposition to SB 187.

Thank you Madame Chair and I would be happy to answer any questions.

Attachments

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 12-1

AMTA Code of Ethics

This Code of Ethics is a summary statement of the standards by which AMTA members agree to conduct their practices and is a declaration of the general principles of acceptable, ethical, professional behavior.

Massage therapists shall:

1. Demonstrate commitment to provide the highest quality massage therapy/bodywork to those who seek their professional service.
2. Acknowledge the inherent worth and individuality of each person by not discriminating or behaving in any prejudicial manner with clients and/or colleagues.
3. Demonstrate professional excellence through regular self-assessment of strengths, limitations, and effectiveness by continued education and training.
4. Acknowledge the confidential nature of the professional relationship with clients and respect each client's right to privacy.
5. Conduct all business and professional activities within their scope of practice, the law of the land, and project a professional image.
6. Accept responsibility to do no harm to the physical, mental and emotional well-being of self, clients, and associates.
7. Refrain from engaging in any sexual conduct or sexual activities involving their clients.

Attachment 12-3

Kansas Chiropractic Association

Kansas Senate Public Health and Welfare Committee
SB 187
February 19, 2001

The Kansas Chiropractic Association (KCA) appreciates the opportunity to offer testimony in regard to SB 187. The KCA is opposed to this bill for several important reasons.

SB 187 would permit a physical therapist to perform a diagnosis on the human living body even though physical therapists have no training in differential diagnosis. The Kansas Chiropractic Association believes it is in the public's interest for all diagnosis to remain in the hands of properly trained doctors who are licensed to practice the healing arts.

The KCA also opposes SB 187 because it would allow physical therapists to have direct access to patients without referral from, consultation with or examination by a physician. The Kansas Chiropractic Association does not believe any treatment should be initiated before the patient has been properly examined by a doctor and before all contraindications to treatment have been ruled out. Since physical therapists cannot perform blood tests or x-ray studies and have no training in differential diagnosis, a physical therapist has no way to determine if bone cancer is the cause of a patient's back pain. That risk to Kansas citizens is further compounded by the fact that physical therapists are not required to carry malpractice insurance.

And finally, the Kansas Chiropractic Association opposes SB 187 because it would allow physical therapists to perform manipulation and we would like to use the remainder of our time discussing this important issue.

Spinal manipulation has been proven to have clinical benefit, relieving symptoms and improving function for low-back pain, neck pain, and headache. The appropriate management of spinal pain by manipulation offers significant savings in direct and indirect costs for workers' compensation, managed care, and indemnity insurance delivery systems.

Since manipulation has demonstrated benefit to patients with these types of complaints and the potential for savings to the system, there has been a resurgence of medical interest in these treatment procedures. This is clearly evident with the expansion in use of spinal manipulation by osteopaths and doctors of physical medicine. In addition, third-party payers and employers are extending chiropractic benefits to their subscribers or employees. Physical therapists have attempted to capitalize on the expanding market for manipulation services and in our opinion, was the basis for adding the word "manipulation" to SB 187 (page 1, line 37).

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Our concern about authorizing physical therapists to perform manipulation is based on three academic and ethical grounds.

1. Differential Diagnosis Prior to Manipulation

The ability to differentially diagnose and to evaluate indications and contraindications for manipulation is a critical feature of its appropriate use. Successful manipulation depends on identification of any co-existing pathology, anatomical or post-operative deficits and the ability to appropriately modify the treatment procedures to accommodate them. It is also important to differentiate disease that mimics manipulable lesions. This could include kidney, heart, stomach, gall bladder, prostate, uterine disease or infection, and tumors.

Doctors of chiropractic are well qualified to differentially diagnose and perform manipulation through extensive academic training, as well as clinical internship. A survey of chiropractic college programs reveals the following details in regard to the training doctors of chiropractic receive in diagnosis and manipulation technique:

- Clinical and differential diagnosis training: 830 clock hours (+/-90)
- Manipulation technique: 600 clock hours (+/-77)
- 6-12 months clinical internship

In comparison, physical therapists receive **zero clock hours** of undergraduate and clinical training in manipulation (Attachment A, page 7) and are not trained in differential diagnosis.

2. Skill Required to Perform Manipulation

Although physical therapists attempt to blend the terms "mobilization" and "manipulation" under the heading of manual therapy when they testify before state legislatures across the country, there is a big difference in the two procedures and the risk associated with each.

> "Mobilization" is movement applied singularly or repetitively within the physiological range of joint motion, **without imparting a thrust or impulse**, with the goal of restoring joint mobility.
>
> "Manipulation" is a passive manual maneuver during which the joint is carried beyond the normal physiological range of movement without exceeding the boundaries of anatomical integrity. The **essential characteristic is a dynamic thrust** - a brief, sudden and carefully administered "impulsion" that is given at the end of the normal passive range of movement which results in an audible release.

As you can see, the primary difference between the procedures is very easy to understand. "Mobilization" is **without thrust** (which physical therapists are qualified to perform) and "manipulation" is **with thrust** (which physical therapists are not qualified to perform.)

The University of Calgary and the Texas Back Institute studied the issues and the mechanics of manipulation and proved the treatment to be a complex procedure that requires significant understanding for safe and effective use. The loads that can be applied are significant and-used improperly or under the wrong circumstances-are like any other effective therapy in that they may result in complications.

It was also demonstrated that skill can be quantified and is not transferable. That is, a person skillful in a manual task cannot presume to be able to apply new procedures with similar skill and safety. Thus, weekend seminars, used of late as the basis for learning manipulation by physical therapists, are insufficient and pose the risk of

unskilled application and potential harm to patients. And again, this potential harm to patients is made worse by the fact that physical therapists in Kansas are not required to carry malpractice insurance.

Physical therapists have made statements claiming long-standing historical use of manipulation procedures. The only data on interdisciplinary use of spinal manipulation were reported by a collaboration of doctors of medicine and chiropractic from the RAND Corporation in 1992. Their article, entitled "*Spinal Manipulation for Low-Back Pain*," was published in the *Annals of Internal Medicine*. It uses information from the RAND Health Insurance Experiment database which is one of the largest and most comprehensive sets of data available on the use of health care services in the United States. From those data, they concluded the following:

> "In our analysis of data from the RAND Health Insurance Experiment, chiropractors delivered 94 percent of the manipulative therapy."

With this unequivocal report of actual data on use rate, two facts become obvious.

A. The claim that there is broad, historical use of manipulation by physical therapists is not true.

B. Since manipulation is not widely used by physical therapists, according to the data, it is not surprising that they can state that there have been few physical therapy malpractice claims filed. It is also not surprising since many states (including Kansas) do not require physical therapists to carry malpractice insurance.

Regardless of what the Kansas Physical Therapy Association implies, manipulation also cannot be attributed to them on the basis of state and federal laws. To our knowledge, not a single state authorizes physical therapists by statute to perform spinal manipulation. In fact, the opposite is true since many states and the federal government expressly prohibit physical therapists from performing spinal manipulation. Here are just a few examples (with our emphasis added):

Florida - "The practice of physical therapy as defined in this chapter **does not authorize** a physical therapist practitioner to practice chiropractic medicine as defined in 460, **including specific spinal manipulation**." (Attachment B)

Arkansas - "Practice of physical therapy means...manual therapy techniques including soft tissue massage, manual traction, connective tissue massage, therapeutic massage, and mobilization (passive movement accomplished within normal range of motion of the joint, **but excluding spinal manipulation** and adjustment)" (Attachment B)

Tennessee - "**No person** licensed under Tennessee Code Annotated, Title 63, **may perform a spinal manipulation** or spinal adjustment without first having the legal authority to **differentially diagnose** and have received a minimum of **four hundred (400) hours** of classroom instruction in spinal manipulation or spinal adjustment and a minimum of **eight hundred (800) hours** of supervised clinical training at a facility where spinal manipulation or spinal adjustment is a primary method of treatment." (Attachment B)

California Attorney General Opinion - "Therefore, we believe that the adjustment and manipulation of 'hard tissues,' that is bones and bone structures, is peculiarly a chiropractic technique **beyond the scope of authorized activity for a physical therapist**." (Attachment B)

Kansas Attorney General Opinion - "It is thus our opinion that while manual manipulation as defined generally may include methods of practice authorized to one or another profession or both, chiropractic manual manipulation as taught in accredited schools of chiropractic **is not within the scope of practice of medicine and surgery** as defined by K.S.A. 65-2869." (Attachment C)

Kansas Board of Healing Arts (April 12, 1986) - "**Only licensees of this board** may perform manipulation of the articulations of the human body." [Note: Mid-level practitioners were not licensees of the Board in 1986.]

U.S. Department of Health and Human Services - "...**a physical therapist is not qualified to provide a 'physicians service'** because such a practitioner does not meet the definition of 'physician' in Section 1395x(r) and, therefore, **cannot be paid by Medicare** for providing the service defined in 1395x(r)(5) as **manual manipulation of the spine** to correct a subluxation." (Attachment D)

3. Risks of Untrained Persons Performing Manipulation

By the extensive training afforded doctors who use manipulation procedures, appropriate use is extraordinarily safe However, complications do occur. While severe complications yielding permanent damage are rare when performed by a doctor (0.000001 percent), the proportion associated with manipulation administered by those other than doctors is alarmingly high.

Past testimony by the Kansas Physical Therapy Association has stated that they are unaware of any injuries as a result of physical therapists performing manipulation. Examination of the literature, in fact, shows many cases of physical therapy injury. In Terrett's data (Attachment E), 20 percent are from therapists and others. In an additional 30 cases of complication (incorrectly attributed to chiropractors), 13 percent were actually caused by physical therapists who were attempting to perform manipulation.

With 94 percent of manipulation being performed by doctors of chiropractic, one would expect that approximately 94 percent of serious complications would be associated with them and only 6 percent by others. But that is not the case. And when severe complications are scaled based on the usage rate, the risk of a severe complication **was three times higher for physical therapists** than for doctors of chiropractic! (Attach. F, p 31)

Clearly, there is a need for competent, safe, and effective use of manipulation for patients who need it. Given all the facts, doctors -- and specifically doctors of chiropractic -- are the best equipped to diagnose, administer treatment, and evaluate and respond to any complications that arise.

Under these circumstances, and in the interest of the best quality of care for Kansas patients, the Kansas Chiropractic Association respectfully urges the committee to reject SB 187. However, if this committee and the Legislature are desirous of extending licensure to physical therapists, the Kansas Chiropractic Association will not oppose SB 187 if the following three amendments are made:

- "Physical therapy diagnosis" is changed to "physical therapy impression" (page 1, line 31)
- "Thrust manipulation" is expressly excluded from physical therapy practice (page 1, line 37)
- Referral by a doctor (including a licensed chiropractor) is retained (page 2, lines 13-17; page 7, lines 22-24)

The Kansas Chiropractic Association appreciates the opportunity to discuss our public protection concerns and will be happy to answer any questions at the appropriate time.

Kansas Chiropractic Association
Proposed Amendments to SB 187

Section 1. (a)

(1) Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations and disability or other health and movement related conditions in order to determine a physical therapy ~~diagnosis~~ impression, prognosis or plan of therapeutic intervention and to assess the ongoing effects of intervention;

(2) alleviating impairments and functional limitations by designing, implementing and modifying therapeutic inventions that include, but are not limited to, therapeutic exercise; functional training in self care and in-home, community or work reintegration; manual therapy including soft tissue and joint mobilization ~~and manipulation~~ but excluding thrust manipulation; therapeutic massage; assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient related instruction;

Section 1.

(c) "Physical therapist" means a person who practices physical therapy as defined in this act and delegates selective forms of treatment to supportive personnel under the supervision of such person. Any person who successfully meets the requirements of K.S.A. 65-2906 and amendments thereto shall be known and designated as a physical therapist and may designate or describe oneself as a physical therapist, physiotherapist, registered *licensed* physical therapist, P.T., Ph. T. or ~~R.P.T.~~ *L.P.T. Physical therapists may evaluate patients without physician referral but may initiate treatment only after consultation with and approval by a physician licensed to practice medicine and surgery, a licensed chiropractor, a licensed podiatrist or a licensed dentist in appropriately related cases.*

Sec. 9. (a)

(8) initiating treatment without prior consultation and approval by a physician licensed to practice medicine and surgery, by a licensed chiropractor, by a licensed podiatrist, or by a licensed dentist; and

Attachment 18-5

Foundation for Chiropractic Education and Research

A

Manipulation in the Curricula of Chiropractic, Osteopathic, Physical Therapy and Medical Schools

Michael R. Hillyer, D.C.

704 E. 4th Street
Des Moines, Iowa 50309
Phone 800-622-6309
Fax 515-282-3347

Attachment B-6

Manipulation in the Curricula of Chiropractic, Osteopathic, Physical Therapy and Medical Schools

by Michael R. Hillyer, D.C.

THE RELEASE OF THE AHCPR GUIDELINES for Acute Low Back Problems in Adults marks the arrival of chiropractic as an integral part of the American health care system. Spinal manipulation, in a period of 20 short years has evolved from "unscientific quackery" to a position as the standard of care for low back pain. As noted by Scott Haldeman, M.D., D.C., Ph.D., in The BackLetter, "A tremendous outcomes research effort—combined with an impressive level of organization on the part of chiropractors and other proponents of manual therapy—has transformed the reputation of manipulation over a two-decade span."[1] Haldeman spoke on the role of manipulation at the 15th Annual Spinal Disorders Conference in Atlanta. "Outcomes research has led to the legitimization of a treatment modality that was regarded in the medical community as quackery twenty years ago."[1]

Who Performs Manipulation?

The past 20 years of research has culminated in extremely positive reviews by those in governmental agencies. Early studies, such as the 1979 New Zealand Commission Report, stated: "Modern Chiropractic is far from being an 'unscientific cult,'[2] Chiropractic is a branch of the healing arts specialising in the correction by manual therapy of what chiropractors identify as biomechanical disorders of the spinal column. They carry out spinal diagnosis and therapy at a sophisticated and refined level."[2] The extensive 1993 study by the Ontario Ministry of Health on The Effectiveness and Cost-Effectiveness of Chiropractic Management of Low Back Pain, known as the "Manga Report," is emphatic when it states, "There should be a shift in policy now to encourage the utilization of **chiropractic** services for the management of LBP, given the impressive body of evidence on the effectiveness and cost-effectiveness of these services, and on high levels of patient satisfaction."[3] The Manga Report further states, in its section on Policy Recommendations and Reforms, "In our view, the constellation of (a) the effectiveness and cost-

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effectiveness of **chiropractic** management of LBP, (b) untested, questionable and even harmful use of medical therapies by physicians, (c) the economic efficiency of **chiropractic** over physician care for LBP, (d) the safety of **chiropractic** care and (e) the preference and satisfaction expressed by patients of **chiropractic**, together offers an overwhelming case in favour of much greater use of **chiropractic** services for the management of LBP"[3] (emphasis added).

The Rand Institute in The Appropriateness of Spinal Manipulation for Low-Back Pain states, "A recent analysis of a community based sample of patients showed that chiropractors delivered 94 percent of all the manipulative care for which reimbursement was sought, with osteopaths delivering 4%, and general practitioners and orthopedic surgeons accounting for the remainder."

Given that an overwhelming majority of a particular method of care is being provided by a single profession, and that the AHCPR guidelines favor manipulative treatment for the millions of sufferers of acute low back pain in the United States, it is an important question to ask: What are the educational qualifications of chiropractors and others who may perform manipulation?
In an effort to determine who, by education, is best prepared to perform manipulation treatment, a study was conducted to determine the actual number of classroom hours spent in training practitioners to perform manipulation. The catalogs and bulletins of at least ten from each of the categories of medical schools, osteopathic schools, physical therapy schools, and chiropractic colleges were consulted to determine the amount of education spent on actual manipulation. In cases where adequate information could not be derived from the catalogs, telephone converations with curriculum directors, department heads and others were held to collect the information. If no response was received for requests for catalogs, and if no response could be gained by telephone interview, an attempt was made to find a replacement school. Even then we were unable to reach our goal of 10 respondents in two of the four disciplines investigated.

Manipulation Education in Chiropractic College Curricula

Gary Miller, Ph.D., performed a recent study related to chiropractic technique (manipulation) in 14 chiropractic college curricula.[4] His timely study eliminated the need for us to perform the survey, and has been used as the source of the chiropractic portion of this report. He surveyed the college catalogs and bulletins of 14 chiropractic colleges with the intent of determining the actual

Attachment 13-8

class room hours spent in an academic setting during 1993-1994, in preparing the graduates for manipulation of their patients. The results of this study (Table 1) determined that between 330 and 885 total hours, with a mean of **563** hours, are devoted to preparing graduates from chiropractic colleges in the various aspects of manipulation technique. In actual laboratory hours spent, which is the "hands on" practical training, the amount of time ranged from 225 to 630 hours with a mean of 370 hours. The chiropractic colleges surveyed in Dr. Miller's study are listed in Appendix A.

Manipulation Education in the Curricula of Medical Colleges

Ten Medical Colleges were chosen from a list of the top ten medical colleges in the United States as presented in Peterson's: An Overview Graduate and Professional Programs 1994. Each of the medical institutions were contacted for their catalog or bulletins, which were reviewed for any instruction in manipulation. No mention of manipulation education was found in any of the catalogs, so follow up calls were made to determine if there was any manipulation education that was not mentioned in the catalogs or bulletins. Personal contact with department heads and curriculum chairpersons revealed that there was **no manipulation training** in any of these medical institutions (Table 1). This is understandable in light of the emphasis in the medical education process toward an allopathic, medical/surgical education. The medical schools contacted can be found in Appendix B.

Manipulation Education in Osteopathic Colleges

Ten of the 13 osteopathic colleges listed in Peterson's: An Overview Graduate and Professional Programs 1994, were contacted randomly for copies of their catalogs and/or bulletins. A review of their catalogs and bulletins revealed that the amount of manipulation education contained in the curricula is impossible to determine. Calls to department heads and curricula chairpersons revealed that there is a small amount of manipulation education offered at some schools on an elective basis, and other schools offer "some manipulation training" scattered throughout the curriculum. However, when pressed for an actual number of hours spent on manipulation, the responses ranged from "we don't know," and "the hours are not defined" to a high of 163 at the University of New England. One of the institutions stated that the amount of manipulation in the

curriculum is a "guarded" secret. The range of hours at the institutions who could give a figure is from 128 to 163, with a mean of 146 (Table 1).

This lack of defined manipulation education appears to support a conclusion that manipulation is not emphasized in osteopathic education, consistent with the previously mentioned Rand finding that only 4% of manipulation is provided by osteopaths. The osteopathic colleges contacted and surveyed for this study are listed in Appendix C.

Manipulation Education in Physical Therapy Curricula

Physical therapists, whose domain is physical medicine from an allopathic view point, would seem to be the most logical recipients of manipulation education. However, the survey of ten institutions with quality physical therapy degree programs reveal that physical therapy training in manipulation is also very limited and usually absent (Table 1). The survey of these institutions reveals that there are one or more courses of **"joint mobilization"** taught, but all emphasized that **no joint manipulation** is actually taught. One institution provides classroom discussion in manipulation, but the skill itself is not taught, and another institution reported that "chiropractic manipulation is demonstrated." The schools contacted are listed in Appendix D.

Conclusion

The results of this survey indicate that osteopaths and chiropractors are the only health care providers in the United States currently trained in manipulation, with chiropractors receiving over 4 times the educational training of osteopaths (see Table 1). It seems evident from the amount of manipulation practiced (94 percent of all manipulation is performed by chiropractors) that the only providers currently qualified by education and practice to perform spinal manipulation are chiropractors. It appears that the conclusions of The New Zealand Commission of Inquiry in 1979 are still true today, "General medicine practitioners and physiotherapists have no adequate training in manual spinal therapy, though a few have acquired skill in it subsequent to graduation," and, "Chiropractors are the only health practitioners who are necessarily equipped by their education and training to carry out spinal manual therapy." [2]

The publication of the AHCPR guidelines on Acute Low Back Problems in Adults is the practical fulfillment of the statement made by Paul Shekelle, M.D., Ph.D., who stated in The BackLetter 1994; 9 (6): 61,62,68: that "the evidence on spinal manipulation is much better than for most other back treatments. I think of the treatments that have been tested for acute low back pains, spinal manipulation has probably done the best. There are new treatments that need to be tested and they need it against spinal manipulation to see if they perform better. Spinal manipulation based on its performance in studies to date deserves a prominent role in future research on back pain treatment."

On the issue of who should provide the manipulation so highly recommended in the AHCPR guidelines, these quotes from the Manga Report are self evident: "On the evidence, particularly the most scientifically valid clinical studies, **spinal manipulation applied by chiropractors is shown to be more effective** than alternative treatments for LBP," and, "There is also some evidence in the literature that **manipulations are less safe and less effective when performed by non-chiropractic professionals**" [5] (emphasis added).

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[1] Haldeman, S. The BackLetter 1994; 9 (11):125

[2] Chiropractic in New Zealand, Report of the Commission of Inquiry 1979: 3

[3] Manga, P., et al. A Study to Examine the Effectiveness and Cost-Effectiveness of Chiropractic Management of Low-Back Pain 1993: 80-81

[4] Shekelle, P. et al. The Appropriateness of Spinal Manipulation for Low Back Pain, Project Overview and Literature review 1991: 3

[5] Manga, P. et al. A Study to Examine the Effectiveness and Cost-Effectiveness of Chiropractic Management of Low-Back Pain 1993: 53

Acknowledgment

I wish to thank Robin Holbrook, R.N., for her efforts in acquiring the data necessary to compile this study.

Attachment 13-11

Table 1. Manipulation Education Hours reported by each of the schools of each health discipline.*

School #	DC	MD	DO	PT
1	885	0	163	0
2	750	0	96	0
3	696	0	x	0
4	660	0	128	0
5	612	0	x	0
6	600	0	x	0
7	600	0	x	0
8	525	-	-	0
9	495	-	-	0
10	480	-	-	0
11	450	-	-	-
12	405	-	-	-
13	390	-	-	-
14	330	-	-	-
Mean	563	0	128	0
Range	330-885	0-0	96-163	0-0

* School # is the same as the numerical listing of each school as listed in the appropriate appendix.

x The Manipulative medicine department was not able to determine an actual number of hours dedicated to manipulation education.

Attachment 13-12

APPENDIX A

The Following Chiropractic Colleges Were Included in the Survey Performed by Gary A. Miller, Ph.D., in Chiropractic Technique Vol 6, No. 4, November, 1994:

1. Logan. 885 Total hours/595 Lab hours
2. Los Angeles. 750 Total hours/630 Lab hours
3. Western States. 696 Total hours/540 Lab hours
4. New York. 660 Total hours/450 Lab hours
5. Life. 612 Total hours/336 Lab hours
6. Parker. 600 Total hours/300 Lab hours
7. Palmer West. 600 Total hours/324 Lab hours
8. Palmer. 525 Total hours/330 Lab hours
9. Northwestern. 495 Total hours/300 Lab hours
10. Life West. 480 Total hours/312 Lab hours
11. National. 450 Total hours/285 Lab hours
12. Texas. 405 Total hours/300 Lab hours
13. Cleveland (Los Angeles). 390 Total hours/225 Lab hours
14. Cleveland (Kansas City). 330 Total hours/255 Lab hours

APPENDIX B

The Following Medical Schools Responded:

1. George Washington University. No courses involving manipulation.
2. Thomas Jefferson University. No courses involving manipulation.
3. Ohio State University. No courses involving manipulation.
4. Brown University. No courses involving manipulation.
5. University of Kansas Medical Center. No courses involving manipulation.
6. University of Pennsylvania. No courses involving manipulation.
7. University of Kentucky. No courses involving manipulation.

Attachment 13-13

APPENDIX C

The Following Osteopathic Schools Responded:

1. University of New England. They have an Osteopathic Medicine Manipulation procedures course (163 classroom hours).
2. Philadelphia College. First and second year students receive 1.5 hours per week in manipulation laboratory (94.5 hours total).
3. Michigan State University. Osteopathic techniques in manipulation are taught. It is spread out over the entire program.
4. Oklahoma State University. A total of 128 hours is devoted to Osteopathic Medicine Manipulation. Only a First year, third term course discusses manipulation of joints, it is a 30 classroom hour course.
5. West Virginig School of Osteopathic Mecidine. OMM courses are taught throughout the curriculum, no defined number of hours.
6. Ohio University (Athens). The Osteopathic clinical practice courses (1-6) this accounts for a total of 34 credit hours. Within this course there is a lab for OMM, but the hours for this are not defined.
7. New York Institute of Technology. The actual number of hours of manipulation classes are "guarded." They do not give this information out.

APPENDIX D

The Following Physical Therapy Schools Responded:

1. Duke University. Teaches "joint glides which is a grade 5 mobilization, no quick thrust is taught."
2. Boston University. They make a distinction between mobilization and manipulation. They teach peripheraljoint mobilization and spinal mobilization. This is taught as part of 2 or 3 courses.
3. University of North Dakota. Teaches a summary of all different models of peripheral mobilization, soft tissue activity, and introduction to spinal mobilization (fourth year). No manipulation is taught.
4. University of North Carolina (Chapel Hill). Manipulation is not taught. Grades 1-4 mobilization are taught, but not grade 5 because of North Carolina state laws. A total 2-3 contact hours of mobilization.
5. University of Kansas. "Some" class time is spent on mobilization, but no mechanical torms of manipulation are taught.
6. Old Dominion University. Joint mobiliation is taught, but not manipulation.

Attachment 13-14

7. University of Rhode Island. Manual skills are touched on. No form of quikthrust manipulation is taught.

8. University of South Dakota. No curriculum courses on manipulation.

9. University of Kentucky. Soft tissue and joint mobilization are taught. The chiropractic form of manipulation is demonstrated.

10. Georgia State University. Mobilization of joints is taught throughout their studies in several different classes. No manipulation is taught.

attachment 13-15

B

FLORIDA

REGULATION OF PROFESSIONS AND OCCUPATIONS
Physical Therapy Practice

CHAPTER 486
PHYSICAL THERAPY PRACTICE

486.015 Legislative intent.--The sole legislative purpose in enacting this chapter is to ensure that every physical therapy practitioner practicing in this state meets minimum requirements for safe practice. It is the legislative intent that physical therapy practitioners who fall below minimum competency or who otherwise present a danger to the public be prohibited from practicing in this state.

History.--ss. 1, 24, ch. 83-86; ss. 2, 17, 18, ch. 86-31; s. 4, ch. 91-429.

486.021 Definitions.--In this chapter, unless the context otherwise requires, the term:

(1) "Board" means the Board of Physical Therapy Practice.

(2) "Department" means the Department of Health.

(3) "License" means the document of authorization granted by the board and issued by the department for a person to engage in the practice of physical therapy.

(4) "Endorsement" means licensure granted by the board pursuant to the provisions of s. 486.081 or s. 486.107.

(5) "Physical therapist" means a person who is licensed and who practices physical therapy in accordance with the provisions of this chapter.

(6) "Physical therapist assistant" means a person who is licensed in accordance with the provisions of this chapter to perform patient-related activities, including the use of physical agents, whose license is in good standing, and whose activities are performed under the direction of a physical therapist as set forth in rules adopted pursuant to this chapter. Patient-related activities performed by a physical therapist assistant for a board-certified orthopedic physician or physiatrist licensed pursuant to chapter 458 or chapter 459 or a practitioner licensed under chapter 460 shall be under the general supervision of a physical therapist, but shall not require onsite supervision by a physical therapist. Patient-related activities performed for all other health care practitioners licensed under chapter 458 or chapter 459 and those patient-related activities performed for practitioners licensed under chapter 461 or chapter 466 shall be performed under the onsite supervision of a physical therapist.

(7) "Physical therapy practitioner" means a physical therapist or a physical therapist assistant who is licensed and who practices physical therapy in accordance with the provisions of this chapter.

(8) "Physical therapy" or "physiotherapy," each of which terms is deemed identical and interchangeable with each other, means a health care profession.

(9) "Direct supervision" means supervision by a physical therapist who is licensed pursuant to this chapter. Except in a case of emergency, direct supervision requires the physical presence of the licensed physical therapist for consultation and direction of the actions of a physical therapist or physical therapist assistant who is practicing under a temporary permit and who is a candidate for licensure by examination.

(10) "Physical therapy assessment" means observational, verbal, or manual determinations of the function of the musculoskeletal or neuromuscular system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, postural attitudes, biomechanical function, locomotion, or functional abilities, for the purpose of making recommendations for treatment.

(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water; the use of apparatus and equipment in the application of the foregoing or related thereto; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine. 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 licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466, 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. A health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record. The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter. The practice of physical therapy as defined in this chapter does not authorize a physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460. Nothing in this subsection authorizes a physical therapist to implement a plan of treatment for a patient currently being treated in a facility licensed pursuant to chapter 395.

§ 17-93-102. Definitions.

Arkansas

As used in this chapter, unless the context otherwise requires:

(1) "Practice of physical therapy" means:

(A) Examining and evaluating patients with mechanical, physiological and developmental impairments, functional limitations, and disability or other health-related conditions in order to determine a physical therapy diagnosis, prognosis, and planned therapeutic intervention.

(B) Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include: therapeutic exercise, functional training in self-care as it relates to patient mobility and community access, manual therapy techniques, including soft tissue massage, manual traction, connective tissue massage, therapeutic massage, and mobilization (passive movement accomplished within normal range of motion of the joint, but excluding spinal manipulation and adjustment), assistive and adaptive devices and equipment as it relates to patient mobility and community access, physical agents, mechanical and electrotherapeutic modalities, and patient-related instruction. The therapeutic intervention of bronchopulmonary hygiene, and debridement and wound care requires a physician referral prior to initiation of treatment. Physical therapy shall not include radiology or electrosurgery.

(C) Preventing injury, impairments, functional limitations, and disability, including the promotion and maintenance of fitness, health, and quality of life in all age populations.

(D) Engaging in consultation, testing, education and research.

(2) "Physical therapist" means a person who practices physical therapy as defined in this chapter having successfully completed a curriculum of physical therapy as accredited by the Commission of Accreditation for Physical Therapy Education and having passed a nationally recognized licensing examination;

(3) "Board" means the Arkansas State Board of Physical Therapy;

(4) "Physical therapist assistant" means a person who assists in the practice of physical therapy under the supervision of a physical therapist and who has graduated from an accredited physical therapist assistant program and who has passed a nationally recognized licensing examination.

(A) The physical therapist assistant's function is:

(i) To assist the physical therapist in the patient-related activities;

(ii) To perform procedures delegated to him by the licensed physical therapists that are commensurate with his education and training;

(iii) To function as a participating team member who contributes to total patient care and assists the physical therapist in carrying out complete procedures and programs; and

(iv) To observe and report to his supervisor conditions, reactions, and responses related to his assigned duties.

(B) The physical therapist assistant shall not interpret the orders, perform evaluation procedures, or assume responsibility for planning patient care; and

(5) "Physical therapy aide" means an unlicensed member of the physical therapy team who may perform treatments reviewed and supervised weekly by an on-site physical therapist or physical therapist assistant.

History. Acts 1959, No. 141, § 1; 1979, No. 631, § 1; 1981, No. 470, § 1; A.S.A. 1947, § 72-1317; Acts 1991, No. 1232, § 1; 1997, No. 744, § 1.

Attachment 13-18

Tennessee

CHAPTER NO. 323

HOUSE BILL NO. 1622

By Representatives Odom, Sherry Jones

Substituted for: Senate Bill No. 1652

By Senator Cooper

AN ACT to amend Tennessee Code Annotated, Section 63-4-101, relative to the practice of chiropractic.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 63-4-101, is amended by adding the following language as a new subsection (e):

(e)(1) No person licensed under Tennessee Code Annotated, Title 63, may perform a spinal manipulation or spinal adjustment without first having the legal authority to differentially diagnose and have received a minimum of four hundred (400) hours of classroom instruction in spinal manipulation or spinal adjustment and a minimum of eight hundred (800) hours of supervised clinical training at a facility where spinal manipulation or spinal adjustment is a primary method of treatment. "Spinal manipulation" and "spinal adjustment" are interchangeable terms that identify a method of skillful and beneficial treatment where a person uses direct thrust to move a joint of the patient's spine beyond its normal range of motion, but without exceeding the limits of anatomical integrity. Violation of this section is an unlawful practice of chiropractic and is grounds for the offending health care provider's licensing board to suspend, revoke or refuse to renew such provider's license or take other disciplinary action allowed by law.

(2) Nothing in this subsection shall in any way apply to the scope of practice of:

(A) an osteopathic physician licensed under Tennessee Code Annotated, Title 63, Chapter 9; or

(B) any person who practices medicine or surgery who is licensed under Tennessee Code Annotated, Title 63, Chapter 6.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: May 20, 1999

JIMMY NAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES

JOHN S. WILDER
SPEAKER OF THE SENATE

APPROVED this day of 1999

DON SUNDQUIST, *GOVERNOR*

Pursuant to Article III, Section 18, of the Constitution of the State of Tennessee, the Governor had House Bill No. 1622 in his possession longer than ten (10) days, so therefore the bill becomes law without the Governor's signature.

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California

two categories then established was that registered physical therapists were required to work under the direction or supervision of a physician and surgeon. See 43 Ops. Cal. Atty. Gen. 157 (1964). The two categories were merged in the Physical Therapy Practice Act in 1968 (Stats. 1968, ch. 1284, p. 2415) which does not require that physical therapists work under the direction or supervision of a physician or surgeon. We are informed, however, that most do. In 23 Ops. Cal. Atty. Gen. 179 (1954), we held that the enactment of the two physical therapy statutes in 1953 neither increased nor decreased the scope of the practice of chiropractic, and that a chiropractor could continue to practice physical therapy to the same extent that he could prior to the enactments. The basis for that conclusion was that an initiative measure cannot be amended except by vote of the electors, unless there is a provision in the initiative act authorizing legislative amendments. There is no such authorization in the Chiropractic Act. For the same reason, when the 1968 Physical Therapy Practice Act was enacted, it did not, and could not, alter the permissive range of activity for chiropractors.

We therefore conclude, that just as a physical therapist could not use light, heat, water, exercise and other physical agents for chiropractic purposes, a chiropractor cannot use such agents for physical therapy purposes. A chiropractor may, however, use these and any other agents which are mechanical, hygienic or sanitary measures within the meaning of section 15 of the Chiropractic Act and which do not involve the practice of medicine or surgery, or the use of drugs or medicine, provided such techniques are directly involved in chiropractic procedures.

2. MANIPULATION AND ADJUSTMENT OF HARD TISSUES BY PHYSICAL THERAPISTS

Having determined the extent to which a chiropractor may use physical therapy techniques, we proceed to the question of determining whether a physical therapist may manipulate or adjust the hard tissues (*i.e.*, the spine). It is our opinion that a physical therapist may not directly manipulate or adjust the spine or other bones.

"Adjustment" is not a term used in physical therapy. It is a chiropractic word defined in Schmidt's Attorney's Dictionary of Medicine (1974), at page A-64, as follows: "In chiropractic practice, a manipulation intended to replace a displaced vertebra, or one assumed to be displaced and the cause of symptoms." It is defined in Dorland's Medical Dictionary (23rd Ed. 1957) at page 37 as ". . . a chiropractic word for replacement of an alleged subluxed vertebrae for the purpose of relieving pressure on a spinal nerve." Blakiston's New Gould Medical Dictionary (1st Ed. 1951), at page 26, defines adjustment as a chiropractic treatment aimed at reduction of subluxed vertebrae. We do not believe that adjustment as thus defined, is within the scope of activity permitted a physical therapist under section 2620.

Another term which requires scrutiny is "manipulation of hard tissues." We have been unable to glean from any medical literature a definition of the term "hard tissue." The reference to spine suggests that hard tissue as used in the questions

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presented refers to bones or bony structures of the body. Bone is an osseous tissue, in effect a support, rigid, connective tissue. Blakiston's New Gould Medical Dictionary (1st Ed. 1951), page 147. In responding, we have therefore assumed that hard tissue has reference to bones. "Manipulation" has an accepted medical meaning, being defined in Blakiston's New Gould Medical Dictionary (1st Ed. 1951) at page 592, as "[t]he use of hands in a skillful manner as reducing a dislocation, returning a hernia to its cavity, or changing the position of a fetus."

"Chiropractic" is defined in Blakiston's New Gould Medical Dictionary (1st Ed. 1951), at page 207, as "[a] method which aims at restoring health by palpating the spinal column for subluxations or misplaced vertebrae and adjusting them by hand without other aids or adjuncts."

In 39 Ops. Cal. Atty. Gen. 169 (1962) at page 170, we noted that there was substantial difference between massaging the muscles surrounding the spine and actually manipulating and adjusting the various bones that make up the spine. Based on that observation, we concluded that adjusting the spine by hand for the curing of disease constitutes the practice of chiropractic and under section 15 of the Chiropractic Act is beyond the permissive activity of a physical therapist. We know of nothing that changes that conclusion.

Therefore, we believe that the adjustment and manipulation of "hard tissues," that is bones and bone structures, is peculiarly a chiropractic technique beyond the scope of authorized activity for a physical therapist.

3. MEANING OF PHYSICAL CULTURE AND ITS RELATIONSHIP TO PHYSICAL THERAPY

The final question asks the meaning of physical culture as that term is used in section 302, Title 16, California Administrative Code, and its relationship to physical therapy. We believe that the term physical culture is generally synonymous to physical education and deals with the systematic care and development of the physical body, whereas physical therapy is a system of treatment to rehabilitate or correct bodily or mental conditions.

We have been unable to find the term physical culture defined in any medical literature or in any literature dealing with either physical therapy or chiropractic. Webster's Third International Unabridged Dictionary (1961), at page 1706, defines physical culture as "the systematic care and development of the physique." World Book Dictionary (1975 Ed.) at page 1556 defines it as "the development of the body by appropriate exercise." Encyclopedia Americana (International Ed. 1973) Volume 22, at page 22, refers the reader to the topic "Physical Education."

As previously noted, the term first appeared in the field of chiropractic in the Articles of Incorporation filed in 1904 by the Association of Naturopaths of California, where reference was made to chiropractic and mental and physical culture as permitted materia medica for naturopaths. We find no reference to physical culture in the several Medical Practice Acts since 1904, in the Chiropractic Act, nor

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(C)

State of Kansas

Office of the Attorney General

301 S.W. 10TH AVENUE, TOPEKA 66612-1597

CARLA J. STOVALL
ATTORNEY GENERAL

February 20, 1996

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ATTORNEY GENERAL OPINION NO. 96-12

The Honorable Gary Merritt
State Representative, 20th District
State Capitol, Room 175-W
Topeka, Kansas 66612

Re: Public Health--Healing Arts--Persons Deemed Engaged in Practice of Medicine and Surgery; Persons Deemed Engaged in Practice of Chiropractic; Scope of Practice and Manual Manipulation

Synopsis: The practice of medicine and surgery and the practice of chiropractic are licensed professions each with their own scope of practice as defined by statute. While manual manipulation as defined generally may include methods of practice authorized to one or the other profession or both, chiropractic manual manipulation as taught in accredited schools of chiropractic is not within the scope of practice of medicine and surgery as defined by K.S.A. 65-2869. Cited herein: K.S.A. 65-2869; 65-2871.

* * *

Dear Representative Merritt:

As representative of the twentieth district, you inquire whether the language contained in K.S.A. 65-2869 authorizes physicians to perform manual manipulation. The statute defines persons engaged in the practice of medicine and surgery. It provides:

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> "For the purpose of this act the following persons shall be deemed to be engaged in the practice of medicine and surgery:
>
> "(a) Persons who publicly profess to be physicians or surgeons, or publicly profess to assume the duties incident to the practice of medicine and surgery or any of their branches,
>
> "(b) Persons who prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of whatever nature by the use of any surgical instrument, procedure, equipment or mechanical device for the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder, of human beings.
>
> "(c) Persons who attach to their name the title M.D., surgeon, physician, physician and surgeon, or any other word or abbreviation indicating that they are engaged in the treatment or diagnosis of ailments, diseases or injuries of human beings."

The statute broadly defines the scope of practice of medicine and surgery and includes any person who professes to assume the requisite duties. The statute defines the duties as prescribing or furnishing medicine or performing any surgical operation for the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness of human beings. Additionally, subsection (c) defines the practice as engaging in the treatment or diagnosis of ailments, diseases or injuries in humans. At issue is whether this statute authorizes doctors of medicine and surgery to treat patients by manual manipulation.

When a question of law involves the interpretation of a statute, it is the function of the court to interpret the statute to give it the effect intended by the legislature. ***State v. Gonzales***, 255 Kan. 243 (1994). In construing a statute the court is not limited to the language in that statute but may give general consideration to the entire act. ***McGranahan v. McGough***, 249 Kan. 328 (1991). Thus in order

to determine legislative intent we will consider the act's purpose of protecting the public, K.S.A. 65-2801, and the nature and definition of the other branches of the healing arts act, specifically the practice of chiropractic, in order to construe the statute in question in the context of the entire act. ***Kansas State Board of Healing Arts v. Foote***, 200 Kan. 447, 453 (1968). This analysis is particularly important in light of the prohibition in K.S.A. 65-2836(g) against the unlawful invasion of the field of practice of another branch of the healing arts.

The Kansas Supreme Court considered the language found in K.S.A. 65-2869 in ***Acupuncture Society of Kansas v. Kansas State Board of Healing Arts***, 226 Kan. 639 (1979). At issue was whether acupuncture was prohibited in the practice of chiropractic by a statute which prohibited chiropractors from practicing surgery. The court, reasoning that the legislature could not have intended such a broad interpretation of surgery as to render the healing arts act nonsensical, found surgery to be more limited and thus allowed the practice of chiropractic to include acupuncture as a modality of treatment. 226 Kan. at 645-46. Similarly, we must determine whether manual manipulation, a term not otherwise defined by statute, is within the purview of the practice of medicine and surgery as defined in K.S.A. 65-2869. The question of whether a particular procedure is within the authorized scope of one practice or another is primarily one of statutory interpretation. 73 Am.Jur.2d ***Statutes*** ¶ 195 (1974); 16 A.L.R. 4th 58, 65 (1982).

When construing a statute, ordinary words are to be given their ordinary meaning which means that words used in a statute should be construed according to context and approved usage of the language. ***State ex rel. Stephan v. Kansas Racing Commission***, 246 Kan. 708 (1990). The term manipulation is not found in K.S.A. 65-2869; however it is part of the defined practice of chiropractic, K.S.A. 65-2871. Chiropractors in Kansas are expressly permitted to "adjust any misplaced tissue of any kind or nature, manipulate or treat the human body by manual, mechanical or natural methods. . .," subsection (b). Applying the rule that ordinary words are to be construed according to their context we may conclude that this type of manipulation is part of the definition of the practice of chiropractic, but the fact that manipulation is within the practice of chiropractic does not settle the question of whether manipulation, as a healing art, is within the practice of medicine. ***See Acupuncture Society of Kansas v. Kansas State Board of Healing Arts***, 226 Kan. at 643 (the

definition of the practice of chiropractic should not be used to obliterate the distinction between the practice of chiropractic and the practice of medicine and surgery [dictum]).

In a medical context, the term manipulation is a general term often used to describe procedures performed by medical doctors, osteopaths, physical therapists and chiropractors. 1B ***Attorney's Textbook of Medicine*** 1237 (3d ed.1994). ***See also***: Schmidt, ***Attorneys' Dictionary of Medicine and Word Finder*** M-39 (1995); 3 ***Ausman and Snyder's Medical Library Lawyers Edition*** 4:29 (1993); ***The Sloan-Dorland Annotated Medical-Legal Dictionary*** 432 (1987); ***Stedman's Medical Dictionary 5th Unabridged Lawyer's Edition*** 832 (1982). As such the procedures performed vary, giving the term different definitions depending on the context in which it is found. ***See generally, Mississippi Farm Bureau Mutual Insurance Company v. Garrett***, 487 So.2d 1320 (Miss. 1986) (opinions of doctors of chiropractic are not barred by the sole ground that the field overlaps medicine.) As a general matter, manual manipulation may constitute the practice of various professions dealing with the well-being of one in need of treatment; the term, however, is defined in different ways depending on the particular practice in which it is found. In other words, the term manual manipulation is defined in context. For example the term manipulation is defined in ***Stedman's Medical Dictionary, ibid.***, as "any manual operation; ***e.g.*** palpation (examination by means of the hands p. 1018), extracting the fetus in difficult labor, or expressing the placenta." One would be hard-pressed to argue that the extraction of a fetus in difficult labor is not the practice of medicine simply because the procedure might involve dextrous treatment by the hand. In ***Sloane-Dorland Annotated Medical Legal Dictionary, ibid.***, the term manipulation is defined as the skillful or dextrous treatment by the hand and cites an example from the practice of physical therapy. In ***Attorneys' Dictionary of Medicine and Word Finder, ibid.***, the term is defined as "[s]killful handling in the adjustment of an abnormality or the bringing about a desirable condition, as the changing of the position of the fetus, the alignment of the fragments of a broken bone, the replacement of a protruding organ (in hernia), etc."

It is clear from these examples that the term manual manipulation is not a term of art which has only one definition and found only within one practice or another. Thus, a finding that manual manipulation as generally defined is not authorized by K.S.A. 65-2869 as the practice of

medicine and surgery would render the healing arts act nonsensical. K.S.A. 65-2869, subsection (c) broadly defines the practice of medicine and as a practical matter must include some of the procedures that are treatment by skillful use of the hands when one is "engaged in the treatment or diagnosis of ailments, diseases or injuries of human beings." However, the fact that the term has many meanings does not mean that there is no distinction between the manual manipulation provided by doctors of medicine and the treatment provided by doctors of chiropractic. We note in the interest of clarity that doctors of osteopathy (D.O.s) who are licensed to practice medicine and surgery pursuant to K.S.A. 65-2870 are outside the scope of our question regarding K.S.A. 65-2869.

The legislature clearly intended the distinctions between healing arts branches not be obliterated. K.S.A. 65-2835(g) prohibits a licensee from the invading the field of practice of any branch in which the licensee in not licensed to practice, and in ***Kansas State Board of Healing Arts v. Burwell***, 5 Kan.App.2d 357 (1980) the court upheld the revocation of a chiropractor's license when it held that Laetrile was properly found to be a medicine or drug, the use of which by chiropractors was expressly prohibited.

Thus the overlap of the term does not mean that the professions or healing arts themselves overlap. ***See McKissick v. Fry***, 25 Kan. 566, 592 (1994) (chiropractors are allowed to treat patients within the scope of specific therapies permitted by the healing arts act.) For this reason it is useful to discuss manual manipulation in the context of the practice of chiropractic. Chiropractic manipulation may involve lumbar invertebral joint adjustment which is a passive manual maneuver during which the three joint complex is suddenly carried beyond the normal physiological range of movement without exceeding the boundaries of anatomical integrity. Kirkaldy-Wallis, ***Managing Low Back Pain*** 287 (2d ed., 1988). And while so defined in this publication, the term manual manipulation may be broader and may include other procedures in the context of the practice of chiropractic as defined in our state.

Similarly, K.S.A. 65-2869 which defines the practice of medicine broadly is not a license to practice a modality of treatment specific to another field of the healing arts. However, manual manipulation is a term which encompasses many different treatments, specific to and limited by the context in which the term is found.

In light of the possible interpretations for the term manual manipulation, in our judgment the term must be interpreted in context. It is thus our opinion that while manual manipulation as defined generally may include methods of practice authorized to one or another profession or both, chiropractic manual manipulation as taught in accredited schools of chiropractic is not within the scope of practice of medicine and surgery as defined by K.S.A. 65-2869.

Very truly yours,

Carla J. Stovall

CARLA J. STOVALL
Attorney General of Kansas

Guen Easley

Guen Easley
Assistant Attorney General

CJS:JLM:GE:jm

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D

PHYSICAL THERAPISTS ARE PROHIBITED FROM PERFORMING MANIPULATION BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) AND THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)

The American Chiropractic Association (ACA) Files Federal Lawsuit Against the U.S. Department of Health and Human Services (*ACA v. Shalala*) on Nov. 12, 1998

Among other things, the ACA's complaint and its amended complaint argued that physical therapists as non-physicians may not provide the uniquely chiropractic service of manual manipulation of the spine to correct a subluxation, which is also a Medicare physician service.

HCFA's Change of Position - December 8, 1998 letter to the ACA from Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration.

The receipt of the above-referenced letter by the American Chiropractic Association (ACA) approximately one month after ACA's filing of its lawsuit, detailed a substantial change in position by HCFA on the issue of physical therapists providing manual manipulation of the spine to correct a subluxation. The letter states in part the following:

> We have carefully considered the issues you and others raise regarding the Medicare covered benefit, manual manipulation of the spine to correct a subluxation. The manual manipulation of the spine to correct a subluxation revealed by x-ray is expressly referenced as a covered physician service. For purposes of providing the services only, the statute also states that a chiropractor is included in the definition of "physician". It does not follow, however, that this service cannot be provided by others who meet the definition of physician for all purposes, such as osteopaths. While M + C organizations are obligated to provide the benefits with access to all Medicare - covered services, including manual manipulation of the spine meeting Medicare coverage criteria, they are not under an obligation to provide this service through a particular type of "physician." (emphasis added)

The above language makes it clear that this service is to be provided by a "physician". Chiropractors, osteopaths and medical doctors are all defined as "physicians" under the Medicare statutes (42 U.S.C. § 1395x (r)); physical therapists are not. Therefore, Medicare's prior policy enunciated in the Secretary's July 8, 1998 letter that the service may be provided by "physicians and other practitioners" had been changed to a position that the service may only be provided by a "physician", and physical therapists are not "physicians."

Additional Confirmation Of Change In Policy - Letter February 19, 1999 from Nancy-Ann Min DeParle, HCFA Administrator to Congressman Lane Evans

The Administrator of HCFA restated the change in policy in a separate letter to Congressman Lane Evans which states in part:

> For the purposes of providing this service only, the statute states that a chiropractor is included in the definition of "physician". Therefore, under the statute this service may be provided not only by a chiropractor, but by other individuals who meet the definition of physician for all purposes as well. (emphasis added)

Again, physical therapists do not meet the definition of physician for Medicare purposes and, therefore, may not provide the physician service of manual manipulation of the spine to correct a subluxation.

June 17, 1999 Testimony of Dr. Thomas Gustafson, Director HCFA Plan and Provider Purchasing Group Before the Practicing Physician Advisory Council (PPAC).

Attached is a portion of the official transcript from the above-referenced meeting of the Practicing Physician Advisory Council. During the Council deliberations, Dr. Gustafson was asked a specific question as to whether non-physicians or physical therapists may provide the service of manual manipulation of the spine to correct a subluxation. His response was no and he elaborated as follows:

> Because there has been some confusion about the ability of physical therapists to be paid for delivering this service under Medicare, and I believe at one time, we --- our interpretation was yes, that was okay, we have come to a more mature understanding of what the statute in fact provides, and physical therapists are not permitted to bill Medicare or to be billed for Medicare for this service. (emphasis added)

Dr. Gustafson's comments were completely consistent with the letters of December 8, 1998 and February 19, 1999 from the HCFA Administrator, clearly showing the change in position from the policy enunciated by the Secretary in her July 8, 1998 letter.

September 2, 1999 - Position Taken by the Government in it's Memorandum of Points of Authorities in Support of its Motion to Dismiss *ACA v. Shalala*

As previously indicated, the ACA filed suit to, among other things, stop physical therapists from providing the Medicare physician services of manual manipulation of the spine to correct a subluxation. In response to ACA's complaint, the government stated to the District Court on page 10, footnote 8 of its above-referenced memorandum, the following:

> Thus, we agree with Plaintiff that an M+C organization could not purport to make this physicians service available to enrollees through a physical therapist, and must have physicians available to perform this service (whether it be chiropractors or other physicians who perform manual manipulation). (emphasis added)

Again, a clear and unequivocal statement by the government to the District Court that this service must be performed by a physician and cannot be performed by a physical therapist who is not a physician.

November 4, 1999 Letter to APTA Counsel by Lena Robins

It is important to note, that what appears to be a clear change in policy restated not once but on four separate occasions by official representatives of Medicare, including the HCFA Administrator herself, has been confused by a letter written on November 4, 1999 by the governments lead attorney (Ms. Lena Robins) in *ACA v. Shalala*. In that letter the government's attorney, without any legal reference whatsoever, stated that physical therapy services "may be offered to an enrollee as an alternative to receiving the physicians' service ..." (emphasis added). The letter has been a source of confusion since it has been interpreted by some to take a position different from the position taken by the government before the District Court. It is interesting to note that Ms. Robins withdrew her appearance from the pending lawsuit after the ACA filed a memo complaining about the letter with the District Court. Nevertheless, the letter continues to obfuscate the distinction between physical therapy services and physician services. Under no circumstances is there legal authority under the Medicare laws to allow physical therapists to perform manipulation of the spine to correct a subluxation, a physician service.

November 26, 1999 - Reclarification of policy to Federal District Court in *ACA v. Shalala*

The government filed a response with the District Court in connection with ACA objection to the Robins letter of November 4, 1999. In its response, the government reclarifies its position as originally stated to the District Court and again states in unequivocal terms:

> As explained in footnote 8 of the Secretary's Motion to Dismiss, a physical therapist is not qualified to provide a "physicians' service" because such a practitioner does not meet the definition of "physician" in Section 1395x(r) and, therefore, cannot be paid by Medicare for providing the service defined in 1395x(r)(5) as manual manipulation of the spine to correct a subluxation. (emphasis added) (footnote 2, page 3)

SPINAL MANIPULATION INJURIES

E

The following case studies of cerebral vascular injuries were as a direct result of spinal manipulation performed by physical therapists, naturopaths, a kinesitherapist, and a lay person.

Case 1: Parkin et al published a case study of a 23 year old female suffering injury after spinal manipulation by a physical therapist. The manipulation resulted in a left vertebral artery occlusion. The patient had a residual deficit with a Babinski-Nageotte syndrome.

Case 2: Fritz et al reported injury to a 63 year old male after manipulation by a physical therapist. The manipulation resulted in medullary brainstem infarct. The patient required six weeks hospitalization and had residual hemiparesis, dysarthria, and dizziness.

Case 3: Neilsen published a case study of injury to a 44 year old female after manipulation by a physical therapist. Two manipulations were performed which produced balance problems, nausea, vomiting, dysphonia, dis-orientation and memory disturbance. Four years after the manipulation injury, there was no improvement in the patient's symptoms.

Case 4: Schmitt et al reported injury to a 35 year old female by a cervical manipulation by a naturopath. There was a thrombosis of the basilar and left vertebral arteries. Death occurred three hours after the manipulation.

Case 5: Schmitt reports another similar case of a 35 year old female manipulated by a naturopath. There was a dissecting aneurysm of the left vertebral artery with intramural hematoma, which extended into the lower basilar artery. This damaging manipulation also resulted in the death of the patient.

Case 6: Gutmann reported injury to a male after manipulation by a naturopath. Due to a previous fracture of the atlas, subsequent tension to the vertebral artery resulted in fourteen days of blindness with later tunnel vision.

Case 7: Gutmann reports manipulation to a 36 year old male by a naturopath resulted in cerebellar ischemia producing vertigo, nausea, and vomiting for several days. After released from the hospital, the patient made an abrupt movement which again resulted in an episode of the ischemia.

Case 8: Masson et al reports manipulation by a kinesitherapist to a 33 year old female resulted in a Wallenberg Syndrome.

Case 9: Ford et al reported injury to a 37 year old male after cervical manipulation by his wife. There was a thrombosis of the basilar, left posterior inferior cerebellar and left posterior cerebral artery. Death occurred sixty hours after the manipulation.

SOURCE: Allan G. J. Terrett, DipAppSc, BAppSc, GrandDipTertEd, F.A.C.C.S.; Lecturer, Dept. of Diagnostic Sciences; Phillip Institute of Technology; Bundoora, Victoria, Australia; "Vascular Accidents from Cervical Spine Manipulations: Report on 107 Cases," ACA Journal, April 1988.

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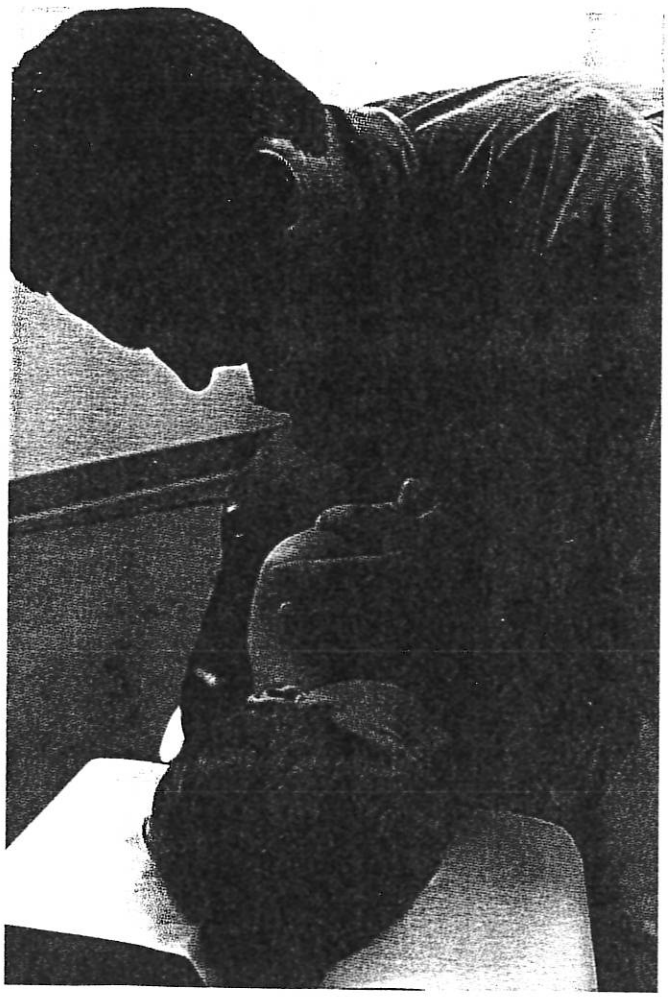
(F)

When It Comes to Spinal Manipulation, Skill Still Counts

John J. Triano, DC, PhD, recently testified before the Texas Senate and House. At issue was whether physical therapists should be authorized to perform spinal manipulation procedures. This is what he had to say:

My name is John J. Triano. I am a chiropractor with 26 years experience, practicing in Plano, Texas, for the past five. I serve as co-director of conservative medicine and director of the chiropractic division at the Texas Back Institute. I also serve as the director of chiropractic services for the Kelsey-Seybold clinics in Houston. As a member of the adjunct faculty for the Biomedical Engineering Center, I teach graduate courses in orthopedic biomechanics, joint biomechanics, and spine biomechanics. I have the privilege of serving as an adjunct professor at the Texas Chiropractic College in Pasadena, Texas. I hold a Doctor of Chiropractic degree, a Master's degree in physiology, and a PhD in applied mechanics (with a specialty in spine biomechanics) from the University of Michigan in Ann Arbor. I am a voting member of the North American Spine Society (NASS), the American Society of Biomechanics (ASB), the American Society of Safety Engineers (ASSE), the American Chiropractic Association (ACA), and the Texas Chiropractic Association (TCA). As a consultant, I have served the National Institutes of Health (as a scientific reviewer), the National Institute of Occupational Safety and Health/Occupational Safety and Health Administration, and the Agency for Health Care Policy and Research. I currently serve on the Texas Workers Compensation Commission (TWCC) Medical Advisory Committee work group on spine treatment guidelines.



Spinal manipulation has been shown to have clinical benefit, relieving symptoms and improving function for low-back pain, neck pain, and headache (e.g., Reviews and Meta-analyses by Van Tulder et al. 1997, Shekelle et al. 1992, RAND 1994). The appropriate management of spine pain using these methods offers significant savings in direct and indirect costs for workers' compensation, managed care, and unmanaged (indemnity) care delivery systems (Jarvis et al. 1991, Stano and Smith 1996, Triano and Hansen 1998).

Chiropractic is responsible for providing the majority of this treatment, with 94 percent of manipulation services being administered by doctors of chiropractic (Shekelle et al. 1992). Since the science of manipulation has demonstrated benefit to patients with these types of complaints and the potential for savings to the system, there has been a resurgence of medical interest in these treatment procedures. This is clearly evident with the expansion in use of spinal manipulation therapy (SMT) by

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osteopaths, doctors of physical medicine, and rehabilitation specialists. In addition, third-party payers and employers are extending chiropractic benefits to their subscribers or employees.

Physical therapists have also attempted to capitalize on the expanding market for manipulation services; it is the foundation for the current legislative initiative. The basis for our concern can be found on three academic and ethical grounds.

1. **Diagnosis.** The ability to differentially diagnose and to evaluate indications and contraindications for manipulation is a critical feature of its appropriate use. Successful manipulation depends on identification of any co-existing pathology or, anatomical/post-operative deficits and the ability to appropriately modify the treatment procedures to accommodate them. It is also important to differentiate disease that mimics manipulable lesions. This could include kidney, heart, stomach, gall bladder, prostate, uterine disease or infection, and tumors.

"weekend seminars, used of late as the basis for learning manipulation by physical therapists in Texas, are insufficient and pose the risk of inappropriate and unskilled application to patients in Texas"

All of the U.S. Office of Education-recognized first professional-degreed providers (e.g., MDs, DOs, DCs) undergo extensive academic training, both before and after graduation, as well as clinical internship and postgraduate specialty training. A survey of chiropractic college programs shows the following related details:

- Clinical and differential diagnosis training: 830 (+/-90) hours
- Physiotherapy/physiological therapeutics: 106 (+/-57) hours
- Manipulation technique: 600 (+/-77) hours
- 6-12 months clinical internship
- Residency programs: 300 hours to certification eligible for diagnosis or rehabilitation, among other subspecialties.

Texas chiropractic educational institutions have 895 hours (Pasadena) and 855 hours (Dallas) for diagnosis. With respect to treatment, they offer 555 hours (Pasadena) and 675 hours (Dallas) for manipulation. Texas licensure requires passing all four parts of the National Board Exam, two of which test clinical knowledge and skills in both topics, as well as a minimum of 120 hours in physiological therapeutics.

2. **Skill.** Manipulation, also called spinal adjustment, consists of the controlled loading of the spine to alter joint and tissue stresses, restore motion, and relieve symptoms. Dr. Joe Montgomery-Davis, also of the TWCC Medical Advisory Committee, has indicated that there are over 25 osteopathic manipulative procedures for treatment of the lower back. In chiropractic, for the primary system of treatment (diversified), there are over 45 methods for the lower back, 25 for the neck, and 17 for the thoracic spine. The proper selection and matching of patient with procedure depends on the nature of the manipulable lesion and the associated diagnosis and complicating factors.

There are two laboratories in North America that have studied these issues and the mechanics of these procedures: the University of Calgary and my own (e.g., Triano et al. 1995, Triano and Schultz 1997, and Triano et al. [in submission]). Spinal manipulation has proven to be a complex procedure that requires significant understanding for safe and effective use. The loads that can be applied are significant and—used improperly or under the wrong circumstances—are like any other effective therapy in that they may result in complications.

Our work (Cohen et al. 1994, Triano et al. [in submission]) has demonstrated that skill can be quantified and is not transferable. That is, a person skillful in a manual task cannot presume to be able to apply new procedures with similar skill and safety. Thus, weekend seminars, used of late as the basis for learning manipulation by physical therapists in Texas, are insufficient and pose the risk of inappropriate and unskilled application to patients in Texas. Such a circumstance raises the prospect of economic waste, clinical inefficiency, and potential harm to patients.

Physical therapists have submitted statements claiming long-standing historical use of manipulation procedures. The only data on interdisciplinary use of spinal manipulation were reported by a collaboration of doctors of medicine and chiropractic from the RAND Corporation and the Los Angeles College of Chiropractic in 1992 (Paul Shekelle, MD; Alan Adams, DC; Mark Chassin, MD; Eric Hurwitz, DC; and Robert Brook, MD). Their article, titled "Spinal Manipulation for Low-Back Pain," was published in

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the Annals of Internal Medicine. It uses information from the RAND Health Insurance Experiment database, one of the largest and most comprehensive sets of data available on the use of health care services in the United States. From those data, they concluded that:

"In our analysis of data from the RAND Health Insurance Experiment, chiropractors delivered 94 percent of the manipulative therapy."

and

"Spinal manipulation accounts for between 61 percent and 92 percent of all services for which reimbursement is sought."

With this unequivocal report of actual data on use rate, two facts become obvious.

1. The claim that there is broad, historical use by physical therapists cannot be sustained.
2. Since the procedures are not widely used by physical therapists, according to the data, it is not surprising that they can state that there have been no physical therapy malpractice claims filed.

Like the credentialing of medical privileges for hospitals, the right to perform any procedures must be backed by evidence of adequate training, skill, and experience. That domain for SMT cannot be attributed to physical therapists in light of the comparison of data on these criteria.

Risks:

By the grace of God and the extensive training afforded doctors who use manipulation procedures, appropriate use is extraordinarily safe (Haldeman et al. 1999a, 1999b [in press]). Complications do occur. Self-limiting, mild systems of new local pain account for the majority and occur in as many as 12.5 percent (Haldeman 1992a,b, Haldeman 1993, Senstad et al. 1997). The rate of other minor complications requiring appropriate diagnosis management is three percent, comparable to the risk rate of many surgical and medical procedures. While severe complications yielding permanent damage are rare (0.000001 percent, Haldeman 1992), the proportion associated with manipulation administered by those other than doctors (DCs, DOs, MDs) is alarmingly high. With 94 percent of procedures performed by chiropractors, one would expect that approximately 94 percent of serious complications are associated with their treatment and only 6 percent by others. Examination of the literature, in fact, shows this to be false (Terrett 1995). In Terrett's data, 20 percent of complications are from therapists and others. In an additional 30 cases of complications incorrectly attributed to chiropractors, 13 percent were actually caused by physical therapists attempting manipulation.

"While severe complications yielding permanent damage are rare (0.000001 percent, Haldeman 1992), the proportion associated with manipulation administered by those other than doctors (DCs, DOs, MDs) is alarmingly high."

It is a fact of clinical practice that any effective treatment, used improperly or on the wrong subject, can result in harm. In 1995, the Quebec Task Force (Spitzer et al. 1995) emphasized the importance of training in use of these procedures. For the sake of argument, let us assume that all cerebral vascular accidents (CVAs) associated with manipulation were performed by chiropractors (a fact already shown false); the rate of these complications is extraordinarily small at approximately one in 1 million (McGregor 1995). This is contrasted to the risk of non-steroidal anti-inflammatories used routinely for osteoarthritis, for example. Approximately 15 percent of patients on ibuprofen had ulcers larger than 5 mm after 12 weeks. (Roth 1993) In other populations, there is a three- to five-fold increase in rate of hospitalization for, and death from, peptic ulcers. (Gabriel 1991)

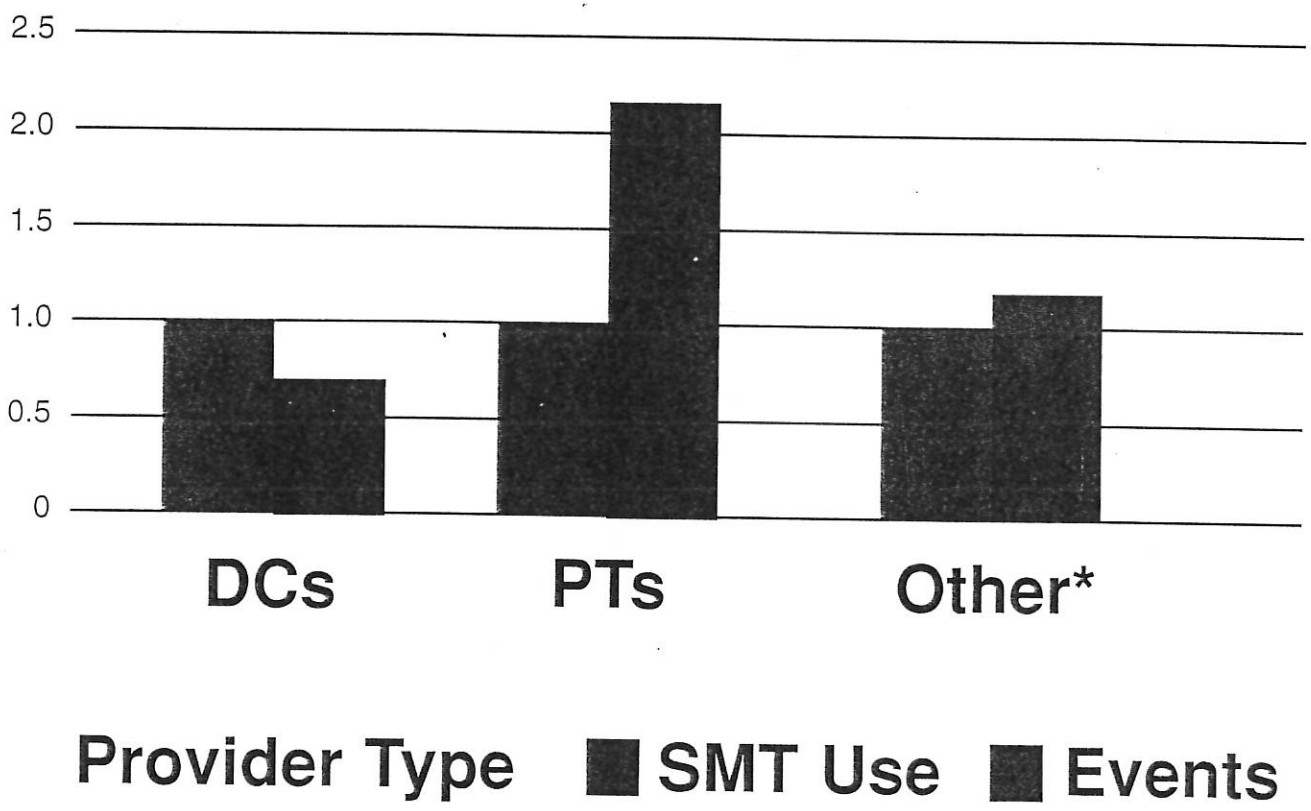
Clearly, there is a need for competent, safe, and effective use of SMT for patients who need it. Given all the facts, doctors and, specifically, doctors of chiropractic are the best equipped to diagnose, administer treatment, and evaluate and respond to any complications that arise.

Under these circumstances, and in the interest of the best quality of care for spine-care patients, I recommend the adoption of the bill that limits use of these methods to licensed, first professional-degreed health care providers (DCs, DOs, MDs) in Texas. ▼

Dr. Triano has compiled a graph, comparing the percentage of severe complications, or "events," from spinal manipulation therapy as performed by doctors of chiropractic, physical therapists, and non-medical practitioners:

Attachment 19-35

SMT Severe Complications Scaled (% Incidence / % Use Rate)



DC use 94%

All other <6%

"Other *" = Non-medical

From: Shekelle et al, Annals of Int Med, 1992 Terrett, JMPT, 1995

Attachment 13-36

Kansas Association of Osteopathic Medicine

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Testimony to the
Senate Committee on Public Health and Welfare
Regarding Senate Bill 187
By Charles L. Wheelen
February 19, 2001

The Kansas Association of Osteopathic Medicine is opposed to SB187 because it would repeal the requirement that physical therapists consult with a physician or other surgeon prior to initiating treatment (page two, lines 14-17). Furthermore, we are not aware of any compelling evidence that licensing of physical therapists would improve quality of care.

We believe that before any patient undergoes treatment or therapy for any medical condition or physical disability, he or she deserves the benefit of a medical evaluation and diagnosis. If a patient's pain or discomfort is attributable to some type of disease, the patient should be treated for the disease rather than receive physical therapy. In some cases, an appropriate medical regimen should precede or be administered in conjunction with physical therapy.

Senate Bill 187 would allow the physical therapist to examine, evaluate, and test individuals without any kind of physician order or referral (page one, line 28). This bill would also allow the physical therapist to alleviate impairments and functional limitations without consulting with the patient's physician (page one, line 33). This is sometimes described as "direct access" but in fact constitutes unrestricted independent practice.

The question of independent practice has been considered by previous Legislatures and a compromise was agreed to. As a result, patients already have "direct access" to physical therapists. Under current law, physical therapists may evaluate patients without any kind of physician's order or referral, but must consult with a physician, a podiatrist, or a dentist before initiating treatment. The reason podiatrists and dentists are included along with physicians is because they sometimes perform surgery, and their patients need physical therapy as a part of the post-operative regimen.

We respectfully recommend that any request for legislation upgrading the statutory credentials of a health care provider group be subjected to a basic test. Can it be demonstrated that changing the status of the occupation will improve the quality of care that your constituents receive from the health care delivery system? If not, there is no need to further consider the request.

Thank you for considering our comments.

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 14-1

PRHIRIE MOON
Health Clinic P.A.

February 19, 2001

To Whom it May Concern,

I would like to address the issue of Senate Bill 187 that would put therapeutic massage and medical massage under the physical therapists or physicians.

I am apposed to this for many reasons:

First off as a teacher of sports massage I have had physicians, physical therapist, and nurses come to my classes that do not have any experience in Sports massage and have learned techniques that follow therapeutic/medical massage therapy and bodywork. Some of the physical therapist have verbalized that they may have learned some of the propreoceptive nerve facilitation (PNF) techniques but do not currently use them in practice as physical therapists.

Sport massage can be considered therapeutic and medical massage because the health of an athlete's muscles are restored with PNF stretches, trigger point, manual lymph drainage and massage so they can continue to train in an aggressive manner. Sports massage also teaches assessment to massage therapists, because they are seeing the client anyway and they need to know if the client needs to be seen by a doctor for sprains and strains. Many clients have been seeing massage therapists for sprains and strains because they did not get what they needed from other caregivers.

Physical therapy is only paid for by insurance for a short period of time and then the client is still left with residual effects of an injury that is still needing to be dealt with. Since physical therapy is so much more expensive client seek out massage therapy.

Massage therapy also takes a different approach than physical therapy. Massage therapy looks at the whole person rather than what is the dysfunction of a back, shoulder, hand and so on. But, massage therapy also includes anatomy, physiology, kinesology, pathology, energy work, shiatsu and many more modalities.

Many people go to a massage therapist because they have complaints about tooth pain or ear pain and the doctor turns them away because they cannot find anything wrong with them. A massage therapist will be able to work with them because massage therapy will help to release tight contracted muscles that are giving them pain. To my knowlege I do not see physical therapy marketing for this type of client. I also have many clients that have been to physical therapy and do not feel that they get the kind of care that they need. Examples: I have one client that has tortocollis and the only thing that relieves his pain and discomfort is massage therapy. He has reported to me that he has been to physical therapy and that has not relieved his discomfort. I find physical therapy's approach is to have the client exercise, ultrasound, and TENS units. There is not much hands on work

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 15-1

C. Tucker Allen, ARNP-CNM • Paulette Danielson RN, NCMT
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done per this client.

I have other clients that have terminal cancer and are hanging on by a thread so I provide relief from the nausea so they can feel well enough to eat. Physical therapy does not provide this type of service that I am aware of.

The American Massage Therapy Association (AMTA) is working toward licensure for massage therapist that will be brought to the legislative session in 2001. Massage therapy needs to stay separate from these other entities so that people have different options for relief of pain and discomfort. If medical/therapeutic massage is placed under the physical therapists how will that be policed when a massage therapist is providing massage therapy. There is always some type of medical benefit from a massage.

I thank you for you time,

Sincerely,

Paulette Danielson

Paulette Danielson, RN, NCMT

Attachment 15-2

KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

Senate Bill No. 187

to the
Senate Committee on Public Health and Welfare

Written Testimony
by
Lesa Roberts, Director, Health Occupations Credentialing
February 19, 2001

Madam Chairperson, I am pleased to provide written testimony to the Senate Committee on Public Health and Welfare regarding Senate Bill 187. In particular, this bill seeks to change the existing level of credentialing of physical therapists from "registered" to "licensed" without benefit of a technical review which is prescribed by the Kansas Act on Credentialing. This bill is similar to several other credentialing bills which have been considered in recent years in which a health care provider group seeks credentialing without applying for a technical review. I have monitored no less than 28 bills relating to the issue of credentialing in the past five years. There have been at least 18 bills during that period that are specific to a request for licensure. Conversely, there have been two applicant groups which have completed the requirement of the Credentialing Act during that same period.

The bill before you pertains to the practice of physical therapy. The bill: 1) substitutes licensing of physical therapists in place of registration throughout a number of statutes related to the board of healing arts, provision of professional services, criminal trespass, insurance coverage, definitions of "health care provider," and protection from liability for provision of services; 2) replaces broad title protection language with more defined language; and 3) provides a detailed listing of practitioners excluded from the act.

The critical component of the bill is in the definition of "physical therapy" which is amended from general scope of practice terms to more narrowly defined functions of physical therapy, to include determining *a physical therapy diagnosis . . . and to assess the ongoing effects of intervention.* Additionally, the bill strikes language which restricts initiation of patient treatment by physical therapists until consultation with and approval by a physician licensed to practice medicine and surgery. This creates an independent practitioner where previously the profession was under the supervision of a physician. The added language details the description of the practice and specifically the body of work. It is notable that there are no changes in the level or type of education, training or examination. Therefore, this is simply a move to license rather than register physical therapists without benefit of a credentialing review.

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Representatives of the registered physical therapists have on two occasions contacted the department with interest in making appropriate application under the Kansas Act on Credentialing. The most recent was last August when a representative from the Kansas Physical Therapy Association requested and received a copy of the *Kansas Credentialing Review Program Manual for Applicants* from the department. There has been no further follow up by the group.

In 1999 House Bill No. 2235 was introduced which was very similar to the bill you are considering today. However, HB 2235 did not amend the definition of "physical therapy," nor did it strike language restricting initiation of patient treatment by physical therapists until consultation with/approval by a physician.

There has been no study on the impact to taxpayers which is one of ten criteria in the technical review process of the Kansas Act on Credentialing. Data from the applicant as well as testimony from opponents and proponents is presented during the technical review process which identifies such topics as: the relative harm or endangering of public health, safety or welfare, public needs which are satisfied or benefit achieved by credentialing at this level, the effect of credentialing of this group upon health care and other health care personnel, and whether it is the "least regulatory means of assuring the protection of the public" which is the preferred policy established by the credentialing

With this information in mind, we would respectfully request that Senate Bill 187 not be passed. Thank you again for the opportunity to provide written comments on Senate Bill 187.

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Attachment 16-2

Credentialing Review Program
1980 to Present

Updated January 2001

Senate Public Health & Welfare Committee
Meeting Date February 19, 2001
Attachment 17-1

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Naturopathic physicians *(exempted Board of Healing Arts)*	12/23/80 (ltr) licensure 02/09/81 (app) 04/21/81 (app) 10/08/98 licensure re-application. Letter of intent & fee returned with directions for application process	1/26/82 Denied	Denied	1982 Healing Arts Act amended to include exemption. 1999 HB 2085 2000 HB 2728 2000 HB 2776b 2000 SB 593 Direct to legislature; by-passing HOCA; died in committee
Respiratory therapists *(Board of Healing Arts)*	03/17/82 (ltr) licensure 05/20/83 (app) 05/18/92 (ltr) from registration to licensure	5/24/84 Denied 12/8/93 Denied	9/26/84 Approved 1986 Registered No action	1985 HB 2533 introduced 1986 registration passed 1996 HB 276 1997 SB 242 1999 HB 2215 licensure passed Direct to legislature; by-passing HOCA
Clinical laboratory professionals *(N/A)*	05/19/82 (ltr) licensure 03/11/85 (app) 02/05/88 app revised as required.	7/13/88 Approved (technologists for licensure; technicians for registration)	11/8/88 Denied	1989 HB 2427 Direct to legislature; by-passing HOCA 1990 Died in committee

Credentialing Review Program
1980 to Present

Updated January 2001

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Occupational therapists (Board of Healing Arts)	07/20/82 (ltr) licensure 12/82 (app)	5/3/84 Approved (licensure)	Approved (licensure)	1986 Registration passed 2000 HB 2886b Direct to legislature; by-passing HOCA; died in committee
Therapeutic recreational therapists *(N/A)*	08/09/82 (ltr) unspecified			09/27/83 Secretary denied letter of intent
Athletic trainers *(Board of Healing Arts)*	12/09/82 (ltr) registration 11/18/85 (app) 01/25/89 app revised as required	6/2/89 Approved	8/15/89 Approved	1991 Original bill SB 105 introduced; revised language & resubmitted 1995 Registration passed 1995 SB 57
Professional counselors *(Behavioral Sciences Regulatory Board)*	01/18/83 (ltr) licensure 02/17/84 (app)	8/23/85 Approved (registration) 9/25/85 (licensure)	1/87 Approved (originally Sec. Sabol approved registration; then Acting Sec. Walker reviewed and approved licensure)	1987 Registration passed 1996 Licensure passed 1996 HB 2692 Direct to legislature; by-passing HOCA

Attachment-17-2

Credentialing Review Program
1980 to Present

Updated January 2001

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Marriage and family therapists *(Behavioral Sciences Regulatory Board)*	04/83 (ltr) licensure 11/08/84 (app) 09/87 app revised as required	2/4/88 Approved (registration)	6/9/88 Denied	1990 Registration passed 1996 Licensure passed 1996 HB 2692 Direct to legislature; by-passing HOCA
Dietitians *(Kansas Department of Health and Environment)*	05/26/83 (ltr) licensure 03/05/84 (app)	11/20/85 Approved	1/87 Approved (originally Sec. Sabol approved registration; then Acting Sec. Walker reviewed and approved licensure)	1989 Licensure passed 1989 SB 102
Master's level psychologists *(Behavioral Sciences Regulatory Board)*	08/25/83 (ltr) licensure 10/83 (app)	1/25/85 Approved (registration)	3/20/85 Approved (registration)	1987 Registration passed 1996 Licensure passed 1996 HB 2692 Direct to legislature; by-passing HOCA

Attachment 17-3

Credentialing Review Program
1980 to Present

Updated January 2001

Attachment 17-4

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Physical therapists *(Board of Healing Arts)*	10/26/83 (ltr) licensure (from registration)			7/26/84 Secretary approved ltr of intent Remain registered (KSA 65-2901). 2000 HB 2235 Direct to legislature; by-passing HOCA
Opticians *(N/A)*	03/23/84 (ltr) licensure 10/25/84 (app) 04-88 app revised as required	1/5/89 Denied	5/18/89 Denied	No action
Alcohol and drug abuse counselors *(Behavioral Sciences Regulatory Board)*	08/16/84 (ltr) registered 05/25/91 (app)	12/18/91 Approved	1/27/92 Approved	1992 Registration passed (SB 458; KSA 65-6601). 2000 SB 398 2000 HB 2760 Direct to legislature; by-passing HOCA; died in committee
Exercise physiologists *(N/A)*	08/21/84 unspecified			09/12/84 Secretary denied letter of intent

Credentialing Review Program
1980 to Present

Updated January 2001

Attachment 17-5

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Sanitarians *(N/A)*	04/05/85 (ltr) registered 12/15/87 registered (application process changed; Kansas Credentialing Act amended 4/24/86; rules & regulations effective 5/1/87.)			04/17/90 Applicant withdrew Acknowledged (Applicant/Secretary concur: 1/29/91, sanitarians do not meet definition of health care personnel.)
Dental assistants	07/08/85 (ltr) licensure			10/08/85 Secretary denied ltr of intent; 12/04/86 approved upon appeal; not credentialed.
Lay Midwives *(N/A)*	12/03/85 (ltr) unspecified			01/21/86 Secretary approved; 03/22/86 application withdrawn (fee-related) Request for fee waiver & immunity from prosecution; Direct to legislature; by-passing HOCA 1994 Died in committee
ARNP Nurse Midwives *(Kansas Board of Nursing)*				1983 approved for inclusion in ARNP Act. (K.S.A. 65-1130 thru 65-1134) (K.A.R. 60-11-102)

Credentialing Review Program
1980 to Present

Updated January 2001

Applicant group and State Regulatory Body	Date of letter of intent, date of application and request	Technical Committee recommendation	Secretary's recommendation	Other Notation
Speech-language pathologists and audiologists *(Kansas Department of Health and Environment)*	12/12/85 (ltr) licensure 03/25/86 (app)	03/09/90 Approved	07/19/90 Approved	1991 Licensure approved (HB 2104; KSA 65-6501 et seq.)
Art therapists *(N/A)*	05/27/98 licensure	10/08/98 Denied	12/18/98 Denied	Secretary approved letter of intent 06/02/97; not credentialed
Radiologic technologists *(N/A)*	06/24/83 (ltr) registration 04/09/97 (ltr) licensure 10/12/98 (app)	 10/18/99 Approved	 11/3/99 Approved	07/06/83 Secretary approved application; Direct to legislature; by-passing HOCA 06/02/97 Secretary approved letter of intent 2000 HB 2761; died in committee
Pharmacy Technicians (State Board of Pharmacy)	7/12/99; 5/8/00 (ltr) credentialing			05/10/00 Secretary approved letter of intent

Attachment 17-6