

Testimony Re: HB 2066
Kansa House of Representatives Committee on Health and Human Services
Presented by Daryl Menke, DPT, PROPONENT
January 30, 2013

Mr. Chairman / Distinguished members:

Thank you for the opportunity to speak in support of HB 2066. My name is Daryl Menke. I am a practitioner in a private physical therapy practice with 29 years of experience with degrees conferred by Wichita State and the Kansas University Medical Center. I am a native Kansan, and constituent.

- ❖ **Physical Therapy is an independent body of knowledge and the graduate MUST complete a doctorate, pass a national exam, and in many states provide evidence of continuing education to practice. The fact is this level of education & credentialing aligns with our colleagues in Chiropractic, Dentistry, Optometry, and Podiatry however they do not require approval from and MD - Oral Surgeon – Ophthalmologist – or Orthopedist!**
- ❖ **56 years of case study on patient self- referral for physical therapy services with NO documented evidence of increased harm or increased costs.**
- ❖ **94% of all state legislative bodies in the U.S. have confirmed and approved of some form of patient self- referral for physical therapy services with 36% of those jurisdictions affirming this should have NO restrictions and there has been NO documented evidence of increased harm or increased costs.**
- ❖ **Michael Loughran, President of the Healthcare Providers Service Organization (HPSO), a CNA company that provides professional liability coverage for over 85, 000 physical therapy professionals on January 26, 2011 wrote, “*We currently have no specific underwriting concerns with respect to direct access for physical therapists.*”**
- ❖ **In a study released in May 2012, 78 patients were evaluated by a licensed physical therapist and 74.4% were subsequently referred back to the physician secondary to the PT finding neuro-musculoskeletal disorders (fractures and tumors most common), visceral disorders (cardiovascular involvement most common), and medication-related disorders.**
- ❖ **A study published in 2009 that assessed clinics in the United State and abroad determined patients who had referred themselves needed less physio (physical therapy) intervention than had those experiencing the same problems who had been referred by physicians ⁽²⁾**
- ❖ **A study published in 1994 assessed 11,600 paid direct access physical therapy claims from 1989 to 1993. According to the results, “*concerns that direct access will result in overutilization of services or will increase costs appears to be unwarranted.*” In a follow-up study published in September 2011, that assessed 63,000 episodes of physical therapy care from 2003 – 2007 found that self-referred patients had fewer PT visits and lower physical therapy costs and lower use of related health care services such as diagnostic testing and injections. (OVER 2 DECADES OF RESEARCH)**
- ❖ **The FACTs and INTEGRITY that created the current collaborative language and 2011 Kansas House affirmation of the content of HB 2066 REMAIN the same – NOTHING has changed!**

EVIDENCE

1. Nebraska has had self-referral since 1957, Arizona since 1983 and Colorado since 1988 as well as 34 other jurisdictions. In reality, that's over 56 years of case study! **Your colleagues in these 37 jurisdictions would have repealed their respective statutes if public harm were occurring or costs were spiraling out of control secondary to patient self referral for physical therapy services. THIS IS GOOD PUBLIC POLICY!**
2. **A study published in 2009 collected data from more than 3,000 patients at a total of 34 clinical sites in Canada, Netherlands, New Zealand, Ireland, South Africa, the United Kingdom, and the United States and that patients who had referred themselves needed less physio (physical therapy) intervention than had those experiencing the same problems who had been referred by physicians**⁽²⁾
3. **Physical Therapy is an independent body of knowledge with a unique and defined expertise of practice that is statutorily supported in all 50 States and is recognized by multiple accrediting and credentialing bodies** (see page 5 of this document). **This level of education aligns with our colleagues in Chiropractic, Dentistry, Optometry, and Podiatry. There is NO evidence these providers or PT's in jurisdictions with patient self referral have harmed the public or created increased health care costs in the absence of the "physician gatekeeper theory".**
4. **Michael Loughran, President of the Healthcare Providers Service Organization (HPSO), a CNA company that provides professional liability coverage for over 85, 000 physical therapy professionals has categorically refuted patient self referral has created harm. On January 26, 2011 Mr. Loughran wrote, "*We currently have no specific underwriting concerns with respect to direct access for physical therapists.*"**

Additionally, an article by Sandstrom concluded that, "*cumulative physical therapist malpractice incidence in a state was unrelated to public policy related to direct patient access to physical therapy services.*"⁽³⁾

EVIDENCE (continued)

5. In a study released in May 2012, **78 patients were evaluated by a licensed physical therapist and 58 (74.4%) were subsequently referred back to the physician secondary to neuro-musculoskeletal disorders (fractures and tumors most common), visceral disorders (cardiovascular involvement most common), and medication-related disorders.**

6. *Over-Utilization and cost escalation* fears have been historically and consistently denounced. In 1994 Dr. Jean Mitchell, Georgetown University, and Dr. Gregory de Lissovoy, John Hopkins University, published the report, A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy ⁽⁶⁾, which evaluated the paid direct access physical therapy claims from 1989 to 1993. According to their results, ***“concerns that direct access will result in overutilization of services or will increase costs appears to be unwarranted.”***

7. In September 2011, Pendergast et al. substantiated these claims in their article: A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. ⁽⁷⁾ This study assessed 63,000 episodes of physical therapy care, and the researchers found that self-referred patients had fewer PT visits and lower physical therapy costs and lower use of related health care services such as diagnostic testing and injections. ***“In summary our findings do not support the assertion that self-referral leads to overuse of care or discontinuity in care, based on a very large population of individuals in a common private health insurance plan with no requirement for PT [physical therapy] referral or prohibition on patient self-referral.”***

This is real-time evidence with real patients and practicing Physical Therapists, not unsubstantiated supposition.

Your confirmation of SB 46 affirms the Kansas public’s right to patient self-referral in obtaining services from a licensed Physical Therapist.

Thank you! At this time I welcome any and all questions.

The following national organizations recognize physical therapy as an independent body of knowledge with a unique and defined expertise of practice (this is not an inclusive list):

- 1) American Physical Therapy Association
- 2) All 50 of the United States through Physical Therapy Practice Acts
- 3) American Medical Association
- 4) Commission Accreditation of Physical Therapy Education
- 5) U.S. Department of Education
- 6) Council for Higher Education Accreditation
- 7) American Board of Physical Therapy Specialists
- 8) Federation of State Boards of Physical Therapy
- 9) North Central Association of Colleges and Schools
- 1) Joint Commission on the Accreditation of Healthcare Organizations
- 2) CARF--The Rehabilitation Accreditation Commission
- 3) National Committee for Quality Assurance
- 4) Occupational Safety and Health Administration
- 10) Centers for Medicare and Medicaid Services
- 11) State Workers' Compensation Boards
- 12) CHAMPVA
- 13) State courts and Federal courts
- 14) Insurance Carriers
- 15) Liability Carriers
- 16) Healthcare Integrity and Protection Data Bank
- 17) National Practitioner Data Bank
- 18) PEW Health Professionals Commission

The following Kansas organizations recognize physical therapy as an independent body of knowledge with a unique and defined expertise of practice (this is not an inclusive list):

- 1) Kansas Legislature
- 2) Kansas State Board of Healing Arts
- 3) Kansas Board of Nursing
- 4) Kansas Dental Board
- 5) Kansas Board of Pharmacy
- 6) Board of Adult Care Home Administrators
- 7) Kansas Licensed Speech Pathologists and Audiologists
- 8) Kansas Physical Therapy Association
- 9) Kansas Medical Society
- 10) Kansas Chiropractic Association
- 11) Kansas School Systems
- 12) Kansas Insurance Department
- 13) Kansas Department of Health and Environment
- 14) Kansas Occupational Therapy Association
- 15) Kansas Athletic Trainers Association
- 16) Kansas Osteopathic Association
- 17) Kansas Board of Regents
- 18) Kansas Insurance Companies
- 19) Kansas-based Liability Companies

The National Practitioner Data Bank (NPDB) was established by [Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended \(Title IV\)](#). Final regulations governing the NPDB are codified at 45 CFR Part 60. In 1987 Congress passed Public Law 100-93, Section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987 ([Section 1921 of the Social Security Act](#)), **authorizing the Government to collect information concerning sanctions taken by State licensing authorities against all health care practitioners and entities.** Congress later amended Section 1921 with the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, to **add "any negative action or finding by such authority, organization, or entity regarding the practitioner or entity."** Responsibility for NPDB implementation resides with the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS).

BIBLIOGRAPHY

1. Shoemaker MJ. Direct Consumer Access to Physical Therapy in Michigan: Challenges to Policy Adoption. 2012 Feb. *Physical Therapy*. Vol. 92, no.2: 226 – 250.
2. Ries E. Direct Results Around the World. 2011 June. *PT in Motion*.
3. Sandstrom R. Malpractice by physical therapists: descriptive analysis of reports in the National Practitioner Data Bank public use data file, 1991-2004. *J Allied Health*. 2007 Winter;36(4):201-208.
4. Moore JH. McMillian DJ. Rosenthal MD. Weishaar MD. Risk Determination for Patients With Direct Access to Physical Therapy in Military Health Care Facilities. *J Orthop Sports Phys Ther*. 2005;35(10):674-678.
5. Boissonault WG, Ross MD. Physical therapists referring patients to physicians: a review of case reports and series. *J Orthop Sports Phys Ther*. 2012 May: 42(5): 446 – 54.
6. Mitchel JM. de Lissovoy G. A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy. *Phys Ther*. 1997; 77: 10-18.
7. Pendergast J, Kliethermes SA, Freburger JK, Duffy PA. A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. *Health Services Research*. Published ahead of print September 23, 2011

Malpractice by physical therapists: descriptive analysis of reports in the National Practitioner Data Bank public use data file, 1991-2004.

Sandstrom R.

Source: Department of Physical Therapy, Creighton University, 2500 California Plaza, Omaha, NE 68178, USA. robertsandstrom@creighton.edu

Abstract

As physical therapists increase autonomous practice, medical error becomes more important to public safety and public perceptions of the profession. The **purpose of this study was to describe malpractice by physical therapists in the United States based on physical therapist malpractice reports in the National Practitioner Data Bank between January 1, 1991, and December 31, 2004.** A frequency analysis of data related to physical therapist malpractice reports was performed. The relationship between size of malpractice payment and public policy related to access to physical therapist services and malpractice experience was explored. A total of 664 malpractice reports were found in the study period (mean, 47.73 events annually). California had 114 malpractice events, while Maine and Wyoming had none. The median payment amount for physical therapist malpractice was \$10,000 to \$15,000. "Treatment-related" events and events related to "improper technique" were the most common reasons for a malpractice report. **Incidence of malpractice by physical therapists is low (estimated at 2.5 events/10,000 working therapists/year),** and the average malpractice payment is small (<\$15,000). Typical physical therapist malpractice involves a direct intervention by an early to mid-career therapist in an urban state. **Cumulative physical therapist malpractice incidence in a state was unrelated to public policy related to direct patient access to physical therapy services.**

PMID:18293801 [PubMed - indexed for MEDLINE]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18293801> Accessed January 21m 2013

Risk determination for patients with direct access to physical therapy in military health care facilities.
Moore JH, McMillian DJ, Rosenthal MD, Weishaar MD.

Source : US Army-Baylor University Doctoral Program in Physical Therapy, Fort Sam Houston, TX 78234, USA. josef.moore@us.army.mil

Abstract

STUDY DESIGN: Nonexperimental, retrospective, descriptive design.

OBJECTIVES: This study was designed to ascertain whether direct access to physical therapy placed military health care beneficiaries at risk for adverse events related to their management.

BACKGROUND:

Military health care beneficiaries have the option at most US military hospitals and clinics to first enter the health care system through physical therapy by direct access, without referral from another privileged health care provider. This level of autonomous practice incurs broad responsibilities and raises concern regarding the delivery of safe, competent, and appropriate patient care administered by physical therapists (PTs) when patients are not first examined and then referred by a physician or other privileged health care provider. While military PTs practice autonomously in a variety of health care settings, they do not work independently within any facility. **Military PTs and physicians rely on one another for sharing and collaboration of information regarding patient care and clinical research as warranted.** Additionally, military PTs are indirectly supervised by physicians.

METHODS AND MEASURES:

To reduce provider bias, a retrospective analysis was performed at 25 military health care sites (6 Army, 11 Navy, and 8 Air Force) on patients seen in physical therapy from October 1999 through January 2003. During this 40-month period, 95 PTs (88 military and 7 civilian) were credentialed to provide care throughout the various medical sites. Descriptive statistics were analyzed for total workload, number of new patients seen with and without referral, documented patient adverse events reported to each facility's Risk Management Office, and any disciplinary or legal action against a physical therapist.

RESULTS:

During the 40-month observation period, 472 013 patient visits were recorded. Of these, 112 653 (23.9%) were new patients, with 50 799 (45.1%) of the new patients seen through direct access without physician referral. Throughout the 40-month data collection period, there were no reported adverse events resulting from the PTs' diagnoses or management, regardless of how patients accessed physical therapy services. Additionally, none of the PTs had their credentials or state licenses modified or revoked for disciplinary action. There also had been no litigation cases filed against the US Government involving PTs during the same period.

CONCLUSIONS:

The findings from this preliminary study clearly demonstrate that patients seen in military health care facilities are at minimal risk for gross negligent care when evaluated and managed by PTs, with or without physician referral. The significance of these findings with respect to direct access is important for not only our beneficiaries but also our profession and the facilities in which we practice.

PMID:16294989 [PubMed - indexed for MEDLINE]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16294989> Accessed January 21, 2013

Physical therapists referring patients to physicians: a review of case reports and series.

Boissonnault WG, Ross MD.

Source: Department of Orthopedics and Rehabilitation, University of Wisconsin-Madison, Madison, WI 53706, USA. boissonnaultw@pt.wisc.edu

Abstract

STUDY DESIGN: Descriptive.

BACKGROUND:

An important role for physical therapists in the healthcare delivery system is to recognize when patient referral to a physician or other healthcare provider is indicated. Few studies exist describing physical therapists' evaluative and diagnostic processes leading to patient referral to a physician.

OBJECTIVE:

To summarize published patient case reports that described physical therapist/patient episodes of care that resulted in the referral of the patient to a physician and a subsequent diagnosis of medical disease.

METHODS:

A literature search identified 78 case reports describing physical therapist referral of patients to physicians with subsequent diagnosis of a medical condition. Two evaluators reviewed the cases and summarized (1) how and when patients accessed physical therapy services, (2) timing of patient referral to a physician, (3) resultant medical diagnoses, (4) physical therapists' role in referral of patients for diagnostic testing, and (5) relevant patient symptom description, health history, review of systems, and physical examination findings.

RESULTS:

Fifty-eight (74.4%) of 78 patients had been referred to a physical therapist by their physician, while the remaining 20 patients accessed physical therapy services via direct access. The patients' primary presenting symptoms included pain (n = 60), weakness (n = 4), tingling/numbness (n = 2), or a combination (n = 12). Patient referrals to a physician occurred at the initial physical therapy session in 58 (74.4%) of 78 cases. A majority of patient referrals to a physician (n = 65) were related to primary presenting symptoms, including manifestations inconsistent with physician diagnosis, recent worsening without cause, unusual accompanying symptoms such as fatigue and/or weakness, and inadequate response to treatment. Resultant diagnoses included neuromusculoskeletal disorders (n = 53; fractures and tumors most common), visceral disorders (n = 14; cardiovascular involvement most common), and medication-related disorders (n = 3).

CONCLUSIONS:

This review of published patient case reports provides numerous examples of physical therapists using effective multifactorial screening strategies for referred and direct-access patients, leading to timely patient referrals to physicians. The therapist-initiated patient referral to a physician led to subsequent diagnosis of a wide range of conditions and pathological processes.

A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy.

Mitchell JM, de Lissovoy G.

Source : Graduate Public Policy Program, Georgetown University, Washington, DC 20007, USA.

Abstract

BACKGROUND AND PURPOSE:

Access to physical therapy in many states is contingent on prescription or referral by a physician. Other states have enacted direct access legislation enabling consumers to obtain physical therapy without a physician referral. Critics of direct access cite potential overutilization of services, increased costs, and inappropriate care.

METHODS AND RESULTS:

Using paid claims data for the period 1989 to 1993 from Blue Cross-Blue Shield of Maryland, a direct access state, we compiled episodes of physical therapy for acute musculoskeletal disorders and categorized them as direct access (n = 252) or physician referral (n = 353) using algorithms devised by a clinician advisory panel. Relative to physician referral episodes, direct access episodes encompassed fewer numbers of services (7.6 versus 12.2 physical therapy office visits) and substantially less cost (\$1,004 versus \$2,236).

CONCLUSION AND DISCUSSION:

Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. There are several potential reasons why this may be the case, such as lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists.

Concern that direct access will result in overutilization of services or will increase costs appears to be unwarranted.

PMID: 8996459 [PubMed - indexed for MEDLINE]

Available at:

<http://www.ncbi.nlm.nih.gov/pubmed?term=A%20Comparison%20of%20Resource%20Use%20and%20Cost%20in%20Direct%20Access%20Versus%20Physician%20Referral%20Episodes%20of%20Physical%20Therapy> Accessed January 21, 2013

A Comparison of Health Care Use for Physician-Referred and Self-Referred Episodes of Outpatient Physical Therapy.

Pendergast J, Kliethermes SA, Freburger JK, Duffy PA.

Source: Center for Public Health Statistics, University of Iowa, Room C22K, 200 Hawkins Drive, Iowa City, IA.

Abstract

OBJECTIVE:

To compare patient profiles and health care use for physician-referred and self-referred episodes of outpatient physical therapy (PT).

DATA SOURCE:

Five years (2003-2007) of private health insurance claims data, from a Midwest insurer, on beneficiaries aged 18-64.

STUDY DESIGN:

Retrospective analyses of health care use of physician-referred (N = 45,210) and self-referred (N = 17,497) ambulatory PT episodes of care was conducted, adjusting for age, gender, diagnosis, case mix, and year.

DATA COLLECTION/EXTRACTION:

Physical therapy episodes began with the physical therapist initial evaluation and ended on the last date of service before 60 days of no further visits. Episodes were classified as physician-referred if the patient had a physician claim from a reasonable referral source in the 30 days before the start of PT.

PRINCIPAL FINDINGS:

The self-referred group was slightly younger, but the two groups were very similar in regard to diagnosis and case mix. Self-referred episodes had fewer PT visits (86 percent of physician-referred) and lower allowable amounts (\$0.87 for every \$1.00), after covariate adjustment, but did not differ in related health care utilization after PT.

CONCLUSIONS:

Health care use during PT episodes was lower for those who self-referred, after adjusting for key variables, but did not differ after the PT episode.

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PMID: 22092033 [PubMed - as supplied by publisher]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22092033> Accessed January 21, 2013