

Fall 2010

A Review of Direct Access to Physical Therapy

Tiffany Basore
Grand Valley State University

Follow this and additional works at: <http://scholarworks.gvsu.edu/honorsprojects>



Part of the [Physical Therapy Commons](#)

Recommended Citation

Basore, Tiffany, "A Review of Direct Access to Physical Therapy" (2010). *Honors Projects*. 57.
<http://scholarworks.gvsu.edu/honorsprojects/57>

This Open Access is brought to you for free and open access by the Undergraduate Research and Creative Practice at ScholarWorks@GVSU. It has been accepted for inclusion in Honors Projects by an authorized administrator of ScholarWorks@GVSU. For more information, please contact scholarworks@gvsu.edu.

A Review of Direct Access to Physical Therapy

Tiffany Basore

Advisor: Professor Dan Vaughn

Grand Valley State University

Frederik Meijer Honor's College

Fall 2010

Introduction

The profession of physical therapy is constantly evolving. The physical therapist's scope of practice has expanded throughout history to include more thorough evaluation, examination, and treatment of a wide range of disabilities. Along with these changes have come increased educational standards. Currently, the entry-level degree is shifting from a Masters to a Doctorate of Physical Therapy (DPT) degree. The DPT should enhance critical thinking and integrative competency skills. The American Physical Therapy Association (APTA) hopes that the enhanced educational standards will bring a higher level of respect to the profession and raise support for allowing physical therapists to have more autonomy in practice and increased access to patients (Plack, 2002). These goals are included in APTA's Vision 2020 Statement:

“Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients'/clients' health networks and will hold all privileges of autonomous practice (APTA Vision 2020, 2007).”

Increasing consumer access to care has been a goal in the United States health care system for years. In relation to physical therapy, this issue has been targeted by APTA through legislative efforts to eliminate the physician referral requirement and allow patients direct access to care by a physical therapist. In 1957, Nebraska became the first state to allow direct access to physical therapy followed by California and Maryland in 1968 and 1979, respectively. In the

years since, APTA has actively worked to change state laws to permit unrestricted direct patient access to physical therapy. State laws have continued to change, as have the educational standards of physical therapy. At present, 48 states allow some form of direct access, of which, 16 have no restrictions, 29 have various provisions in place, three allow evaluation only, and two allow no direct access [Figure 1] (APTA, 2010).

Map of Direct Access States

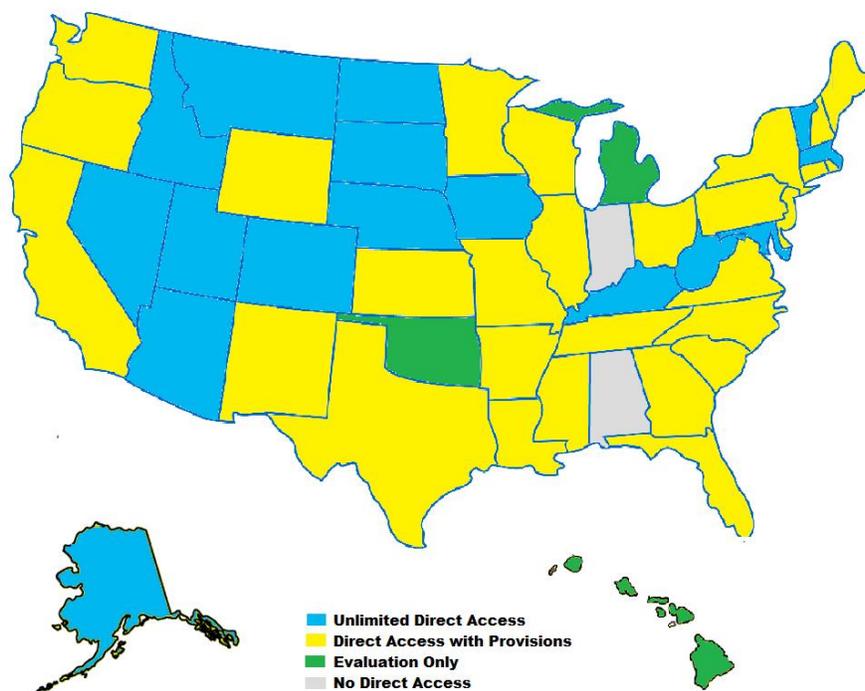


Figure 1. Direct Access laws as of June 2010 (APTA, 2010).

A crucial step towards autonomy lies in legalizing direct access to physical therapy in all states and eliminating barriers and restrictions in states that already allow direct access. Even in states that allow direct access, levels of physical therapy utilization are still low (“Direct Access Utilization,” 2010). The reasons for the low levels of utilization have been studied. One of the

barriers to direct access utilization is reimbursement by third party payers such as Medicare. To target this issue, the advocacy campaign for direct access has been extended to the Federal legislature. In order to achieve true autonomy, insurance providers must pair legality of direct access with reimbursement of direct access services. Furthermore, while some states have no restrictions to access, others have extensive provisions including but not limited to, the requirement that the current problem must have been treated previously, limits on the number of days or visits that a patient can be seen without a physician referral, and clinical experience requirements of the physical therapist prior to treatment of direct access patients (APTA, 2010). Consequently, although significant gains towards direct access have been made at the state-level, there are still many issues that must be addressed in order to provide consumers with this increased patient access to care.

To date, there have been no legislative actions to repeal any existing direct access laws, however, not everyone is convinced of the safety and appropriateness of direct access to physical therapy (APTA, 2004). APTA, along with its state branches and other organizations such as the Canadian Physiotherapy Association, and the American Academy of Orthopaedic Manual Physical Therapists strongly support direct access (APTA, 2009). However, other groups such as the American Medical Association, the American Academy of Orthopedic Surgeons, the American Orthotic and Prosthetic Association, and the American Academy of Orthotists and Prosthetists are critical of eliminating the physician referral requirement (Elliot, 2006). Those opposing direct access cite concerns including patient safety, physical therapists' diagnostic knowledge, and the potential costs associated with direct access. It is these types of concerns that must be continually be addressed in order to overcome the obstacles to APTA's vision statement.

Purpose

The following review of the literature presents the current arguments over direct access to physical therapy including (1) the current usage and reimbursement of services, (2) legislative actions relating to Medicare and direct patient access to physical therapy, and (3) the efforts being made at the state level in Michigan and other non-direct access states towards the Vision 2020 goals of providing consumers with direct access to physical therapy and establishing physical therapy as an autonomous profession. (APTA, 2004).

Federal Legislation

While some form of direct access to physical therapy has been instituted in 48 states, changes in national legislature will be necessary in order for direct access to reach its fullest utilization potential. In the past, Medicare has not covered physical therapy services without a physician referral thereby limiting patients' access to care. Initially, the fight for direct access to care was an issue addressed only at the state level; however in 2001 it was brought to the federal legislature with the introduction of the Medicare Patient Access to Physical Therapists Act to the House of Representatives followed by a similar bill in the US Senate in 2002. These bills addressed the issue of Medicare coverage of physical therapy services under direct access. With Medicare being the largest health care insurance provider in the US, advocates of direct access hoped that if Medicare allowed physical therapy without a physician referral, other providers would follow suit (Massey, 2002).

In conjunction with the Medicare Prescription Drug and Modernization Act of 2003, which aimed to improve patient access to physical therapy, the Medicare Payment Advisory Commission (MedPAC) was directed to study the advisability and feasibility of direct access to

outpatient physical therapy services. MedPAC is an independent group developed in 1997 to advise Congress on issues relating to Medicare policies (Mason, 2005). As a part of the 2003 report, MedPAC investigated the impact that enacting law would have on Medicare and its beneficiaries. At the time of the study, MedPAC committee members included five physicians, but no physical therapists or other rehabilitation providers (Mason, 2005). Ultimately, this bill was put on hold following the MedPAC report to Congress which advised against direct access with concerns relating to patient safety, costs relating to possible overutilization of services, and the ability of physical therapists to appropriately provide care without a physician referral.

Cost and Overutilization Concerns

In response to the 2003 MedPAC statement on direct access to physical therapy, APTA released a report to the MedPAC detailing the feasibility and advisability of direct access to physical therapy in an evidence based fashion (APTA, 2004). As previously discussed, increased costs, and potential for overutilization of services has been an issue of concern relating to implementation and reimbursement of direct access to physical therapy.

Many injuries and conditions presented to a physical therapist involve treatments that are time-sensitive. Often times, the longer the delay between the onset of an ailment and the initiation of treatment, the longer the recovery phase will be. Not only does this potentially cause the patient increased discomfort, it also may result in the need for more visits than would have been necessary had the patient started treatment earlier. The necessity of a physician referral can delay treatment by a physical therapist, which may result in less optimal treatment outcomes, patient frustration, and increased costs. Furthermore, regulations and shortages of primary health care providers can impair timely access to a physician, further delaying access to

physical therapy (APTA, 2004). Improving the timeliness of physical therapy services can help to reduce the level of debilitation caused by an injury or disability as well as promote a quicker return to the patients' previous functional levels.

Studies have continued to provide evidence that allowing direct access to physical therapy would not pose an increased cost to either patients or third party payers such as Medicare. Mitchell and de Lissoy (1997) evaluated Blue Cross-Blue Shield of Maryland claims. The data showed that direct access episodes actually require fewer total visits than cases of physician referral to physical therapy. In conjunction with this, the reduced number of services also resulted in a reduced cost of over \$1200 per episode in the direct access settings. According to a report by the APTA, even a small percentage of patients using direct access could potentially save Medicare millions of dollars each year as well as reduce the cost to the patient by eliminating the co-pay required at a visit to the physician (APTA, 2004). These results indicate that the financial anxiety associated with direct access is unwarranted.

Medicare may further benefit financially from direct access by allowing more of the elderly population to seek treatment for functional deficits in activities of daily living. This goes hand-in-hand with the modernization of Medicare goals to include a preventative effort such as elder falls prevention (APTA, 2004). Some patients with functional deficits may lack an active medical condition and therefore may not be referred to a physical therapist. However, with direct access, the patient could seek treatment for such deficits, potentially preventing more serious and costly injuries related to episodes such as slips or falls. Furthermore, direct access might benefit the profession as it continues to expand to include more prevention and wellness programs. Without the need for a physician referral, individuals would be able to enroll

themselves in these types of programs, ultimately helping to prevent future injuries, disabilities, and diseases (Massey, 2002).

In response to continued efforts by the APTA, the Medicare Prescription Drug and Modernization Act was reintroduced in the 111th Congress in 2009 (“Medicare Patient Access,” 2009). Should this bill pass, it would amend the Social Security Act to allow physical therapists to both evaluate and treat Medicare beneficiaries in an outpatient setting when authorized by state law. This amendment would differ from the current law in that a physician referral would not be required in order for Medicare payment to be approved. It is important to note that coverage is limited only to practice within the scope of the state law. For this reason, in order for APTA’s vision for direct access and goal of total autonomy of practice to be reached, it is necessary to continue to pursue changes at both the state and federal levels (“Medicare Patient Access,” 2009).

Patient Safety

Those in opposition to direct access for physical therapists often lack confidence in a therapists’ ability to correctly identify signs and symptoms of a more serious disease or condition. The concern over physical therapists’ ability to diagnose pathological conditions has led some people to believe that direct access to physical therapy poses a heightened risk to the patient. Although physical therapists are not specifically trained to make diagnoses, they are extensively trained to recognize signs and symptoms that would warrant the need for referral to a physician. Regardless of whether or not a patient is referred to a physical therapist by a physician, the physical therapist will follow the same model of “examination, evaluation, diagnosis, prognosis, and intervention” (APTA, 2004). While pathological diagnoses are left to

the physician, the physical therapist evaluation includes a detailed medical history, a review that screens all of the main bodily systems, and tests to specifically define the presented condition, thereby allowing the therapist to screen for signs and symptoms which would indicate the necessity for further pathological testing (APTA, 2004).

Claims data relating to malpractice and liability of physical therapists show no disparity in patient safety in states with direct access compared to those which require referral by a physician. In order to further safeguard patients under direct access, many states have provisions in place, such as limited time or visits before the patient must see a physician. Additionally, strict regulation and licensure requirements are in place that requires the physical therapist to work within his/her scope of practice guidelines. Licensure must also be renewed on a regular basis, which often requires attendance at continuing education events (APTA, 2004).

In over 20 years of practice under direct access guidelines, there is no evidence to show that physical therapists are unable to appropriately recognize signs and symptoms as pathological or potentially life-threatening. Despite the fact that about 25% of all patient complaints to their primary care physician are musculoskeletal in nature, over half of all medical schools in the United states require no training in musculoskeletal medicine, leaving physicians with very limited knowledge in this area of health care (Childs et al., 2005). Differentially, physical therapists are highly educated health professionals who are not only well-versed in musculoskeletal medicine, but also properly trained to recognize symptoms which would need diagnosis by a physician, yet many physicians, surgeons, and health care groups remain unconvinced (APTA, 2004). A study by Childs et al. (2005) investigated physical therapists' understanding of musculoskeletal conditions in order to address the concern over whether or not they possess the knowledge necessary to safely treat patients without an initial physician

evaluation. This study involved both physical therapy students and experienced physical therapists using the same written examination that had been used in the past on medical students and those completing their physician internships or residencies. With the exception of medical students specializing in orthopaedics, both licensed physical therapists and physical therapy students performed better on the examination than a comparison sample of medical students consisting of individuals at the beginning of their physician residency. Furthermore, students from doctoral programs of physical therapy scored higher than those in master's level programs, suggesting that the higher level degree programs are appropriately increasing the focus on diagnostic aspects of evaluation of musculoskeletal conditions and recognition of emergencies and potential pathological concerns (Childs et al., 2005).

A 2010 Wisconsin based case report on the implementation of a direct access pilot program in a hospital based outpatient program provides additional support for physical therapists' ability to safely provide care without a physician referral, as participating physical therapists' demonstrated appropriate decision-making regarding patient care 100% of the time according to physician reviewers (Boissonnault, Badke, & Powers, 2010). Additional studies of this nature, in areas currently utilizing direct access services or looking to implement new programs, may provide further evidence of the appropriateness of direct access to physical therapy.

Direct Access in Michigan

Currently, Michigan is one of only five states nationwide which does not allow any treatment other than an initial evaluation by a physical therapist without a referral from a physician. In order for Vision 2020 to become reality, Michigan along with Alabama, Indiana,

Hawaii, and Missouri would have to make changes at the state legislative level. Past efforts to change direct access policies in Michigan have been repeatedly unsuccessful, forcing advocates for direct access to take a less remarkable approach in seeking policy changes. Currently, the Michigan Physical Therapy Association (MPTA) is trying to pass a bill that would allow direct access for individuals with established musculoskeletal or neuromuscular conditions, as well as for consultation related to wellness and prevention. This bill is a compromise on MPTA's long-term goal of unrestricted direct access to physical therapy. The hope is that a more conservative approach, initially seeking very minimal, restricted direct access rights, will ease the concerns of legislators who have been resistive to direct access in the past, thereby increasing the likelihood that the bill will pass (Shoemaker, 2007). Should this bill pass, MPTA will continue with progressive efforts towards change through the elimination of restrictions to eventually achieve unrestricted direct access.

Additional Barriers to Direct Access

With most states allowing some form of direct access and the continued effort towards unrestricted direct access, it has become increasingly important to look towards the next step, utilization of direct access. In 2009 APTA conducted a survey that addressed usage, promotion, and strategies associated with the utilization of direct access across a variety of locations and practice settings ("Direct Access Utilization," 2010). This survey was undertaken in order to determine the resources and strategies that might aid in developing programs and increase the utilization of direct access services. As expected, the survey indicated that utilization levels are lower than desired, as about 55% of the respondents stated that they provide direct access and only 14% of that group reported seeing more than 10 direct access patients per week. In addition, 69% of the respondents indicated that their patient load consisted of less than 10%

direct access patients (“Direct Access Utilization,” 2010). The survey further examined the barriers to direct access and found that a restriction was imposed by many employers, i.e. requiring a physician referral prior to seeing a physical therapist. This was especially true in hospital-based settings. Additionally, some states, such as Pennsylvania and Virginia, have restrictions that require the physical therapist to get a State Board Direct Access Certification in order to practice under direct access. To receive this type of certification, physical therapists’ must meet requirements on hours of clinical experience as well as complete a board approved course on evaluation, screening, and examination. Reimbursement concerns were also mentioned, although to a lesser degree than expected. The results of this survey, including respondents input on successful promotional and implementation strategies are being used by APTA’s Departments of Component Services, Payment Advocacy, and State Government Affairs to develop additional resources, including case study examples, to aid various settings in making changes to support and implement direct access in the future (“Direct Access Utilization,” 2010).

Future of Direct Access

Over the past several decades, significant gains have been made towards legalizing direct access to physical therapy. Although several states must still work to gain the legal right to allow patients to seek treatment by a physical therapist without a physician referral, many other states must continue to work towards eliminating some of the restrictions placed on direct access. The American Physical Therapy Association, along with other advocates for direct access, must continue to fight at the Federal level to make legislative changes regarding Medicare and other issues pertaining to direct access and autonomous practice. Other barriers, such as lack of marketing and promotional materials, restrictions by employers, reimbursement concerns, as

well as fear of change and fear of harming relations with sources of referrals must continue to be targeted in order for direct access services to be utilized to their full potential (“Direct Access Utilization,” 2010). Case studies on successful programs, or those working to implement new programs, may help to provide insight on the best approach to effectively and efficiently implementing direct access programs. Additionally, support for direct access may be gained from future studies on patient safety and satisfaction, costs, risks, and benefits of direct access to physical therapy.

Bibliography

- APTA. (2004, August). Establishing the feasibility and advisability of direct access to physical therapists: A report to the Medicare Payment Advisory Commission (MedPAC). Retrieved May 30, 2010.
- APTA Vision 2020. (2007, June). In *American Physical Therapy Association*. Retrieved June 9, 2010, from http://www.apta.org/AM/Template.cfm?Section=Vision_20201&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=39951
- APTA. (2009, October 28). International summit reaches agreement: Patient self-referral to physical therapy improves public health. In *APTA- Direct Access Summit*. Retrieved June 20, 2010 from <http://www.apta.org//AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=65375>
- APTA. (2010, June). A summary of direct access language in state physical therapy practice acts. In *APTA*. Retrieved July 9, 2010 from http://www.apta.org/AM/Template.cfm?Section=Top_Issues2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=22369
- Boissonnault, W.G., Badke, M.B., & Powers, J.M. (2010). Pursuit and implementation of hospital-based outpatient direct access to physical therapy services: An administrative case report. *Physical Therapy*, 90(1), 100-109.
- Childs, J. D., Whitman, J. M., Sizer, P. S., Pugia, M. L., Flynn, T. W., & Delitto, A. (2005). A description of physical therapists' knowledge in managing musculoskeletal conditions. *BMC Musculoskeletal Disorders*, 6(32). doi:10.1186/1471-2474-6-32

- Direct access utilization survey: Executive summary. (2010, February). In *American Physical Therapy Association*. Retrieved July 8, 2010, from http://www.apta.org/AM/Template.cfm?Section=Logout&CONTENTID=72814&TEMP_LATE=/CM/ContentDisplay.cfm
- Elliot, J. (2006, January). Continuing turf battles threaten scope of practice. *PT Magazine*. Retrieved from <http://www.apta.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&CONTENTID=28710>
- Mason, D. (2005, March). Government affairs: Meeting MedPAC's challenge. *Physical Therapy*, 20-23.
- Massey, B. F. (2002). 2002 APTA Presidential Address: What's all the fuss about direct access? *Physical Therapy*, 82(11), 1120-1123.
- Medicare Patient Access to Physical Therapists Act of 2009, S.950, 111th Cong., 1st Sess. (2009).
- Mitchell, J. M., & de Lissovoy, G. (1997). A comparison of resource use and cost in direct access versus physician referral episodes of physical therapy [Electronic version]. *Physical Therapy*, 77(1), 10-18.
- Plack, M.M. (2002). The evolution of the doctorate of physical therapy: moving beyond the controversy. *Journal of Physical Therapy Education*.
- Shoemaker, M. J. (2007). Legislative news. *Shorelines*, 34, 1, 4-5.