Approved: Feb. 19, 93
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on February 15, 1993 in Room 423-S of the Capitol.

All members were present except:
Representative Elaine Wells, excused.

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Commissioner Robert Epps, Income Support/Medical Services, Department of Health and Environment\
Rep. Nichols
Candy Bahner, Director of Physical Therapy program at Washburn University
Jackie Rawlings, Chair of Direct Access Committee, St. Mary's Hospital, Manhattan, Kansas
Ann Carver, Physical Therapist, Topeka Rehabilitation Hospital
Patricia Maben, Director of Adult Care Home Program, Department of Health and Environment
Steve Chandler, President of Kansas Physical Therapy Association
Pauline Beatty, Kansas consumer
Susan Hanrahan, Director of Physical Therapy program, Wichita State University (written testimony only)
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine
Chip Wheelen, Kansas Medical Society
Dr. James Edwards, Kansas Chiropractic Association
Bill Sneed, Legislative Counsel, Health Insurance Association of America

Others attending: See attached list

Chair called the meeting to order requesting those with bill requests to begin.

Commissioner Epps, Department of Health/Environment offered hand out (Attachment No.l) and detailed the request for introduction of legislation that would place a moratorium on beds. He gave rationale, i.e., a moratorium is necessary to create a stronger focus of a community-based service pattern for long-term care and to control growth of long-term-care beds. He noted this will help to control escalating costs. He stated the suggested moratorium is for a five year period.

Rep. Bishop moved to introduce the bill request suggested by Commissioner Epps to place a moratorium on beds. Motion seconded by Rep. Henry. No discussion.Motion carried.

Rep. Nichols distributed a hand out (Attachment No.2), and noted this request is on behalf of the Shawnee County District Attorney's office. The proposed legislation relates to accessible parking for the handicapped. He detailed rationale. Rep. Nichols moved to introduce this bill request, seconded by Rep. Freeborn. No discussion. Motion carried.

Chair directed attention to the agenda and requested a staff briefing on HB2113.

Mr. Furse gave a comprehensive explanation of HB2113, noting changes; proposed new language; policy issues; penalty clauses. He answered questions.

The Chair stated regret at the necessity of limiting conferees to four minutes to present their testimony. There will be time allowed for questions by members.

HEARINGS BEGAN ON HB2113.

Candy Bahner, Legislative Chair of Kansas Physical Therapy Association, (Attachment No.3) gave a comprehensive history of requested legislation by Physical Therapy Association to allow for consumer 's direct access to physical therapy treatment. She detailed conversations with the Kansas Medical Society, Kansas Association of Osteopathic Medicine, Kansas Podiatric Association, Kansas Dental Association, in an attempt to reach a workable compromise. She noted the Kansas Medical Society had compromised on a 10 day limit, but now have backed away from that number. HB 2113 now states 21 days and Kansas Physical Therapy Association (KPTA) feels they are the only group making concessions since they have compromised from no limit of days, to 30, back to 21. She drew attention to the questions in her testimony and noted this part of her testimony will offer an understanding of why direct access is needed, and why KPTA has asked for the proposed changes.

Jackie Rawlings, Chair of Direct Access Committee offered hand out (Attachment No.4).She stated support for HB2113, and noted 28 states have already provided laws for direct access. She noted there has been no increases in professional liability insurance for physical therapists, nor any reported incidents reported related to direct access to physical therapists. She noted in rural communities where all medical services are provided by the hospital and where there is a shortage of physicians, hospital bylaws could allow direct access to physical therapy. This type of direct access to physical therapy has been allowed in the armed forces hospitals since the mid-seventies. She drew attention to a letter from Mr. Keith G. Hauret a former physical therapist in the military, (see Attachment No.5).

Ann Carver, practicing physical therapist supports HB2113. (Attachment No. 5). She explained she formerly was a hatha yoga teacher, and was continually asked questions on how to get relief from pain of arthritis, disc disease, postural problems, frozen shoulders. She noted she had no special training, so returned to school, received her Master of Science in Physical Therapy in 1990 and is currently employed at the Kansas Rehabilitation Hospital in Topeka. She noted the irony of the situation, because of restrictions in Kansas law, she is more limited now as a physical therapist than when she was a yoga teacher. Many teaching aerobics, yoga, nautilus, weight lifting, slimnastics telling the consumer with physical problems what to do or not to do, and as a physical therapist, she is restricted from doing that. She urged for passage of HB2113.

Ms. Carver called attention to a letter from a consumer, see (Attachment No. 6) for details.

Steve Chandler, President of KPTA, provided (Attachment No. 7, and spoke in support of HB2113. He drew attention to letters of support from the Administrator of Horton Community Hospital and several physicians included in his hand out. He noted in his experience, the support of the physicians he works with as a physical therapist is reflected in their referrals which usually read, "Evaluate and Treat, P.T.", or come in the form of a blanket phone referral saying, "Do whatever you feel is needed". Due to the high population of the elderly in rural areas, the recurring treatment on musculoskeletal conditions is repeated, and the referral obtained reads, "Evaluate and treat as indicated". He stated, it is more rational and cost effective for a physical therapist to perform an evaluation, establish and implement a plan of care, or refer to a physician if conditions are indicative of such. He stated physical therapists are trained professionals who are capable of determining symptoms that are not appropriate for physical therapy care, or indicate conditions for which treatment is (outside our scope of knowledge). They are committed to the delivery of quality health services. He noted he practices physical therapy in both Kansas and Nebraska, and Nebraska allows direct access for care. Direct Access does not change the scope of practice. He noted the mutual trust and access for consumers is necessary in rural areas.

Patricia Maben, Director of Adult Care Home Program, Bureau of Adult/Child Care, Department of H/E, offered hand out (Attachment No.8) noted HB2113 would allow a physical therapist to evaluate and provide treatment to an individual for 21 calendar days without a physician's order. There are federal regulations for hospitals, home health agencies and nursing facilities which participate in the Medicare/Medicaid programs that require that rehabilitation services be provided under the direction of a physician. Although the Department of Health/Environment does approve of the concept in HB2113, they are concerned with the conflict of these federal regulations. She drew attention to a balloon amendment in her attachment, and detailed proposed recommended changes, i.e., page 1, line 38 to add after "and" "except when otherwise provided by law". on line 40 to change "21" to "10"(days), page 2, line 37 to change "21" to "10".

Pauline Beatty, a Kansas consumer provided hand out (Attachment No. 9), drew attention to "Report and Recommendations of the Kansas Health Care System" by the Governor's Commission on Health Care, issued 11/28/1990. She noted page 26 of that report deals with the issue of access to primary care. She noted with the passage of HB2113, she would be allowed access to physical therapy without the need to contact a physician. She expressed resentment for the unnecessary waste of resources to go to the doctor for a referral. She is grateful to be ambulatory, many aren't and transportation to the doctor is costly, and in a situation where an elderly person is using a walker, and must continue therapy, the referral is unnecessary. She urged support..

Ms. Beatty urged members to read excerpts from letters enclosed in her attachment.

Susan Hanrahan, Director of Physical Therapy program at Wichita University sent written testimony only directed to HB 2113. (Attachment No.10.)

Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine offered hand out Attachment No. 11), and spoke in opposition to HB2113. He stated great respect for those practicing physical therapy, noting, they are an important part of the health care delivery system, however, he has concerns about the proposed change of permitting physical therapists to initiate treatment of a patient without a physician's referral. He detailed concerns, i.e., diagnosis of an illness is complex and a difficult part of the practice of medicine, and physicians are more extensively trained to do this procedure. He detailed other concerns that should be considered when a proposal of this magnitude is being sought, i.e., impact on health care costs; changes in location patterns of practitioners, (physical therapists); will it exacerbate the shortage of hospital based physical therapy services in rural areas; will the supply/demand of available health care delivery be impacted in recruiting full service physicians. He noted some states have enacted the proposal in HB2113, others have not; some have reached compromises, others have not. He noted the proposed language in HB2438 is a preferred alternative to HB2113.

Chip Wheelen, Director of Public Affairs, Kansas Medical Society, offered hand out (Attachment No.12). He stated the question of "direct access" to physical therapy services has been discussed extensively for about three years by the Kansas Medical Society, and other professional associations, and the Board of Healing Arts, and legislators. The general consensus among the members of the Kansas Medical Society is, when someone is ill, that patient deserves a differential medical diagnosis to conclusively determine the source of the malady. He detailed the procedure. He noted they realize, some patients, although they need a medical diagnosis, will not seek one, instead they will pursue alternative health care services and actually expose themselves to potential injury. For that reason, he noted, if Committee chooses to report HB2113 favorably, the direct access period be shortened to only 10 days, which they believe is the longest time you should consider allowing physical therapists to initiate treatment before a physician is consulted. They believe it is imperative the amendatory language contained in section 2 be retained in the bill. These features were recommended by the Kansas Medical Society to prevent abuse of the direct access time period. He drew attention to amendments that had been referred to by an conferee earlier. The amendment worked on by Mr. Slaughter and Mr. Wheelen begins on page 2, line 36 continuing through line 9 on page 3, and was proposed to try and limit the potential for abuse of direct access. He detailed rationale for this amendment.

Dr. James Edwards, representing the Kansas Chiropractic Association , offered hand out (Attachment No.l3), and spoke in opposition to HB2113. He detailed the differences between licensed practitioners and registered practitioners in an attempt to show the wide disparity of what is allowed for each of these practitioners. He drew attention to the physical therapy law that states a physical therapist, "may initiate treatment after consultation with and approval by a physician". He detailedthat the physical therapy law does not even require an examination or a medical diagnosis prior to treatment, and he feels this is an unacceptable standard. The KPTA is asking you to allow them to do what no licensed doctor can do, are asking for "free rein" for 21 days. If HB2113 is not amended to exclude physical therapists from performing spinal manipulation, anything less than our fervent opposition would be unethical, and a violation of the public trust.

Bill Sneed, Legislative Counsel, Health Insurance Association of America, offered hand out (Attachment No.l4) expressed concerns regarding HB2113, i.e., the elimination of a consultation by a physician before treatment can begin by a physical therapist. He stated, the first request of this Committee, is that since HB2113 would eliminate current law, coupled with the fact that no insurance policies shall deny reimbursement or indemnification for any service within the scope of a practice licensed under the Kansas Healing Arts Act, it would seem that K.S.A. 40-2248 and K.S.A. 40-2249 would be applicable for review by the Committee. He detailed rationale, and suggested a fiscal impact report might possibly be examined by this Committee. He stated further, a concern about the effect on managed care programs, i.e., would new language proposed preclude the managed care providers from requiring an evaluation by a physician prior to being referred for physical therapy? He asked this issue too, should be carefully reviewed by Committee. He stated, it is hoped that if HB2113 is advanced, they want to make sure what is done on the certification , will not cause them to have to require mandated payments, and eliminate their ability to utilize managed care programs.

Numerous questions were posed by members. An explanation was given regarding the referral process; what the law requires, and/or allows, of physical therapists, of doctors; differences defined in the requirements for private pay patients and the patients on Medicaid/Medicare; federal requirements do require that states meet those federal requirements, and it appears those requirements are in an unstable situation at present. It was noted, currently some physicians require a diagnosis, some do not. There were numerous questions asked about concerns on insurance. Questions were asked about concerns on mis-diagnosis; concerns on the number of days allowing treatment before a referral.

Chair adjourned the meeting at 3:05 p.m.

The next meeting is scheduled for February 16, 1993.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

(Mon.)

DATE Feb. 15, 1993

NAME	ORGANIZATION	ADDRESS
[illegible]	SRS	Topeka
Jan Edwards DC	KCA	Emporia
Sue Fairchild	KCA	Topeka
Carolyn Bloom	KPTA	Eudora
Pauline D. Beatty	PT-Consumer	Topeka
Ann Carver	KPTA	Topeka
Sandy Bahnsen PT	KPTA	Belvue
FRANCES Kastner	" "	Topeka
Danita Hull	KPTA	Overland Pk
Marie Rawlins	KPTA	Manhattan
Steve Chandler	KPTA	Hiawatha
Joyce A Kroe	KDHE	Topeka
Arthur Maben	KDHE	Topeka
Rick Liby	Gehrt & Roberts	Topeka
Bill Sneed	NFIB	Topeka
Larry Buening	Bd of Healing Arts	Topeka
[illegible] Wickham	KCA	"
Chip Wheelen	Ks Med Soc	Topeka
David Haggblick	KS Dental Assn	"
Donald L Zoellner	Bd Healing Arts	
Cammie Tiede	Bd Healing Arts	Top
Annette Siebert	KAHA	Topeka
ALAN CobB	Wichita Hospitals	Wichita

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-15-93

NAME	ORGANIZATION	ADDRESS
John Conard	AARP	Lecompton
Jennifer Davis		Lawrence
Sandra Bowman	KPTA	Perry
Julie Newman	KPTA	Oskaloosa

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

House Committee on Public Health and Welfare

Testimony on the Moratorium on Nursing Facility Beds

February 15, 1993

Madam Chairman and members of the committee, I thank you for the opportunity to present you with this testimony.

SRS supports a moratorium that would prohibit additional nursing facility beds for at least five years. Kansas has the nations' highest number of licensed skilled nursing and intermediate care facility beds per 1,000 population age 65 and older. We estimate 87% of all licensed/certified nursing facility beds are in use. Institutional-based LTC costs financed by the Medicaid Program have doubled since FY 1987; and, without effective policy changes, these costs will continue to rise at a rate that cannot be supported by the state's current revenue system.

In 1986/87 there were 27,425 licensed adult care home beds compared to 29,848 total beds licensed in January, 1993. A sample of 304 facilities indicates today that 29% are urban, and 71% adult care homes are rural. Lastly, we estimate 64% are for-profit facilities while 36% are not-for-profit. The immediate result of implementing a moratorium on beds would have no impact on existing nursing facilities and resident care. With an estimated growth rate of 2 1/2% in occupancy, it would take over four years to fill the existing vacant beds in Kansas.

A moratorium on nursing facility beds is necessary to create a stronger focus of a community-based service paradigm for long-term care and to control growth of LTC beds.

There are 39 states with Certificate of Need (CON) Program. The State of Minnesota, which has strong long-term care community-based programs, has a moratorium program.

The moratorium would include a prohibition on the expansion of nursing facility beds through construction, conversion from another licensure category, or the licensing of existing beds which were previously not licensed as nursing facility beds. The conversion of adult care home beds to hospital beds should also be restricted.

An effective moratorium policy relies heavily on stability. There has been some discussion of establishing a time-limited program here in Kansas. We recommend the moratorium be for five years to provide continuity and allow time for the effects of the preadmission assessment and referral program to impact available resources.

Robert L. Epps
Commissioner
Income Support/Medical Services
(913) 296-6750

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Attmt 1

PROPOSED BILL NO. ____

By

AN ACT concerning medical nursing facilities; limitations on new and converted uses.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act:

(a) "Medical nursing facility" means a nursing facility, except it does not include any nursing facility that is operated as an intermediate care facility for the mentally retarded, or a continuing care contract home.

(b) "Bed" means an equipped location at which a patient, client or other individual may receive 24-hour-a-day board and skilled nursing care and treatment.

(c) "Nursing facility" means a nursing facility as defined in subsection (a)(2) of K.S.A. 39-923 and amendments thereto.

(d) "Continuing care contract home" means a home as defined in subsection (c) of K.S.A. 1992 Supp. 40-2231 and amendments thereto where a provider, as defined in subsection (d) of K.S.A. 1992 Supp. 40-2231 and amendments thereto provides continuing care under a continuing care contract, as defined in subsection (a) of K.S.A. 1992 Supp. 40-2231 and amendments thereto.

(e) "Commenced construction" means all necessary local, state and federal approvals required to begin construction have been obtained, including all zoning approvals and contracts for construction have been signed.

(f) "Permanent financing" means the owner of the project has a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans or the owner demonstrates sufficient assets, income or

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financial reserves to complete the project with less than 50% in outside financing.

Sec. 2. On and after the effective date of this act:

(a) No license as a nursing home under subsection (a)(2) of K.S.A. 39-923 and amendments thereto and no certificate of registration as a continuing care provider under K.S.A. 1992 Supp. 40-2235 and amendments thereto shall be issued for a medical nursing facility which, after the effective date of this act, (1) is constructed, (2) is created by conversion from another licensure category, (3) enlarges the licensed capacity of an existing medical nursing facility, or (4) changes a place which is not a medical nursing facility, including any existing nursing facility that is operated as an intermediate care facility for the mentally retarded, into a medical nursing facility, except nothing in this subsection (a) shall apply to facilities which have commenced construction on the effective date of this act or have permanent financing on a project on the effective date of this act.

(b) (1) No medical nursing facility beds that are for all individuals shall be converted to medical nursing facility beds exclusively for individuals receiving mental health care and treatment.

(2) No medical nursing facility beds that are exclusively for individuals receiving mental health care and treatment shall be converted to medical nursing facility beds that are for all individuals.

Sec. 3. The secretary of health and environment may adopt rules and regulations with the concurrence of the secretary of social and rehabilitation services and the secretary on aging which establish procedures and standards under which the secretary of health and environment may grant a waiver of the limitations on the granting of licenses on an individual, regional or state-wide basis.

Sec. 4. The provisions of this act shall sunset on July 1,

1998.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

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3 RS 1037

HOUSE BILL NO. ____

By

AN ACT relating to accessible parking; concerning the marking thereof; providing a penalty; amending K.S.A. 1992 Supp. 8-1,128 and repealing the existing section; also repealing K.S.A. 1992 Supp. 8-1,128a.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1992 Supp. 8-1,128 is hereby amended to read as follows: 8-1,128. (a) Notwithstanding the provisions of K.S.A. 8-2003, and amendments thereto, all designated accessible parking spaces shall be clearly marked by vertically mounted signs bearing the international symbol of access. Such signs shall be displayed with the bottom of the sign not less than 32 inches above the surface of the roadway.

(b) As of January 26, 1992, any owner or lessee of private property available for public use establishing a new parking space or relocating an existing parking space for persons with a disability, shall conform to the following federal regulation: Section 4.6 of appendix A to part 36; nondiscrimination on the basis of disability by public accommodations and commercial facilities, 28 CFR part 36, as required by the Americans with disabilities act of 1990, 42 USCA 12101 et seq.

(c) Violation of this section is a nonperson unclassified misdemeanor.

Sec. 2. K.S.A. 1992 Supp. 8-1,128 and 8-1,218a are hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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ATTM#2

Physical Therapy Association

KPTA

February 15, 1993

Testimony HB 2113

Good afternoon, Representative Flower and members of the House Public Health and Welfare Committee. I am Candy Bahner, the Legislative Chair of the Kansas Physical Therapy Association, a Registered Physical Therapist since 1978, and the Director of the Physical Therapist Assistant Program at Washburn University.

I stand before you today in support of HB 2113 allowing 21 days of direct access to physical therapy services. Currently in Kansas a physical therapist can evaluate a patient without a referral, but prior to initiating treatment must have a referral from a physician licensed to practice medicine or surgery, a licensed dentist or a licensed podiatrist.

The Kansas Physical Therapy Association initiated direct access legislation in 1983 at which time we compromised to evaluation without referral, but an order is required before treatment can be initiated, and most of the time the orders received read "evaluate and treat as indicated". In 1991, we again initiated legislation to allow for direct access in the form of SB 64. It was held over to the 1992 session to allow us to try and compromise with opponents to the bill. Attempts were made with the Chiropractic Association and the Kansas Osteopathic Association

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without success. During the original testimony on SB 64 Chip Wheelen of the KMS deferred the KMS position to the orthopedists who would be most directly involved with SB 64. During the summer of 1991, the 21 day agreement was reached with the Ad Hoc Committee of the Kansas Orthopedic Society. Because of this agreement and Chip's original testimony we thought we had reached a compromise with the Kansas Medical Society when we accepted their balloon proposal of 21 days of direct access, only to have them not support their own balloon. Despite all this the Senate Public Health and Welfare Committee did pass legislation allowing for 21 days of direct access to physical therapy when that committee amended SB 64 into SB 691. Then SB 691 passed the Senate 37-0. It was referred to the House Public Health and Welfare Committee but was not heard in committee. This past November, letters were sent to the Kansas Medical Society, the Kansas Osteopathic Association, the Kansas Podiatry Association, the Kansas Dental Association and the Kansas Hospital Association informing them of our intent to initiate direct access legislation during the 1993 session. I asked them to contact me if they had concerns, and if so, would they be willing to meet with KPTA members to reach compromise language. We received a letter from the Podiatrist asking for information. I also called the KMS and asked them to bring up the direct access topic at their next executive council meeting. In visiting with Chip Wheelen and Jerry Slaughter, I was informed that the council could not agree to 21 days of direct access and that they were sticking to the 10 day limit that they had endorsed last May. I asked Jerry Slaughter for the 10 day endorsement in writing to

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avoid the situation that occurred with the 21 day balloon last legislative session. On February 12, 1993 I called Jerry and asked him about the letter. He said I could pick it up. Attached is a copy of that letter. We were very disappointed that the KMS would back out on their commitment of 10 days of direct access that they had previously endorsed as noted in Dr. Lepse's letter dated November 18, 1992. Jerry's letter indicates that they cannot embrace the concept of direct access, but if the legislature chooses to enact a direct access bill it should not exceed a 10 day limit. The KPTA feels that we are the only ones making concessions since we compromised from no limit of days, to 30 days, and then to 21 days in 1992. We have documentation to warrant our first option of unlimited access has no detrimental affects, and is a benefit to consumers in the 28 states which have direct access.

Over the past three years, I have spoken with many authorities including legislators and other individuals, both professional and non-professional about Direct Access to physical therapy services. In my opinion what opposition exists against direct access is based on misconception, lack of understanding, and unfounded fears outside the profession of physical therapy.

I felt to help clarify this confusion and condense the testimony, it would be helpful to pose common questions and provide a summarized answer based on nationally acquired information retrieved from a 33 year history of direct access in 28 states. Hopefully, this will help those who have concerns and opposition to see that by removal of the "referral" requirement (direct access) for physical therapy treatment, there will be a reduction in

consumer costs and a provision for safe quality care to Kansas consumers.

1. Wouldn't direct access increase cost?

In 33 years increased cost has not been demonstrated in any of the states which have direct access.

- Medicare survey reviewing millions of claims show that physical therapy charges when compared to other practitioners providing the same services were significantly less (46-62% less).
- 1980 Blue Cross/Blue Shield (BCBS, Rochester, New York) reported results same as above.
- Maryland has practiced without referral since 1979. As of 1987, BCBS reported no increase in payments of significance since direct access was initiated.
- 1983 BCBS of Arizona published data on 79 procedures performed by various professionals from 1/1/83 to 8/31/86. When evaluating numerous practitioners, physical therapists demonstrated the most cost-effective treatment.

2. Won't this legislation mandate insurance reimbursement and increase insurance cost?

No. None of the 28 states over the past 33 years have mandated insurance reimbursement. HB 2113 would not mandate insurance reimbursement. Medicare, Medicaid and worker's compensation presently reimburse nationwide only with

referral. Each insurance company sets its own policy for reimbursement. Presently, Aetna, BCBS, Cigna, Equitable, Mutual of Omaha, New York Life, Prudential and Travelers reimburse for physical therapy in most states which have direct access.

Physical therapy has for decades been accepted by, and received payments for services from insurance companies. A combination of the insurance company's familiarity with the effect of physical therapy, in conjunction with recognizing the cost effectiveness in direct access states provides them with the ability to make an independent decision on reimbursing for services without referral, but does not mandate it.

3. <u>Are there other areas which may reduce costs with the implementation of direct access?</u>

Yes, especially when considering risk prevention and health promotion. In the school systems, screening may pick up delayed development in motor skills and potential for athletic injuries. Direct access would allow a physical therapist to evaluate and intervene where necessary and make the appropriate referral to the necessary health care practitioner when conditions exist beyond their scope of practice. Currently school systems are required to provide physical therapy for children with developmental or physical disabilities. In those situations the physical therapist can evaluate the child, but cannot initiate treatment until orders

are received from a physician. It has been documented in some situations this has taken as long as 4 months. Again direct access to physical therapy services would have prevented the delay in services to the child in need.

In industries, ergonomic evaluation, early intervention upon injury, and education in prevention have demonstrated significant savings in lost numbers of employees, lost wages, less injury, and early return to work, all producing less cost to industry, insurance and society as a whole.

Additional costs in prevention may also be evident in the area of fitness. Presently for an individual to receive a fitness evaluation and exercise prescription they would have to be referred to the physical therapist through a physician. This additional cost and time before intervention tends to lead the public along the path of least resistance and seek fitness training from less qualified individuals in the community who do not require a referral. It is somewhat ironic that massage therapists, fitness salon operators, reflexologists, etc. without a college education and possibly the appropriate medical knowledge can provide fitness education to the community without physician referral, all without any State Board of Health over-site, or any consumer protection agency determining their qualifications. But in Kansas, a physical therapist who has professional knowledge and expertise in that area must receive a referral in order to give that information to an individual. It is possible that more injuries occur because of lack of appropriate information

given to an individual about fitness, or the fact that individual may not seek help because of the impaired access to a physical therapist due to the referral requirement.

4. <u>Are physical therapist safe to practice without referral? After all, with a referral doesn't the physician provide the therapist with a diagnosis and order for treatment? How will the independent physical therapist be safe?</u>

Susan Hanranhan, PT will explain in her testimony the competency level of today's physical therapists with problem solving skills in clinical decision making to assist graduates in being competent practitioners. Physical therapists know their scope of practice and have the expertise to recognize problems which fall outside that scope. In those situations we refer the patient to a qualified practitioner.

Consider also that as part of the rules and regulations dictated by the Board of Healing Arts and the Physical Therapy Practice Act in Kansas, physical therapists are required to practice under their Code of Professional Conduct. (Article 37) K.A.R. 100-37-1 states that "physical therapists accept the responsibility to protect the public from unethical, incompetent or illegal acts." The Practice Act and the American Physical Therapy Association Code of Ethics requires physical therapists to assume the responsibility for evaluating, planning, implementing and supervising a therapeutic program. It also requires re-evaluating and changing the program and maintaining adequate records

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including progress reports. When the individual's needs are beyond the scope of the physical therapist's expertise, the individual is to be so informed and assisted in identifying a qualified person to provide the necessary services. Also, when physical therapists judge that benefit can no longer be obtained from their services, they are to so inform the individual receiving the services. It is unethical to initiate or continue services that in the therapist's judgement can not result in a beneficial outcome, or are contraindicated. Physical therapist in Kansas always practice within this scope of practice whether direct access exists or not.

In my opinion, when considering how physical therapists have practiced for three decades in Kansas, the requirement of referral has questionable significance in terms of patient safety and quality of care. Since 1963, physical therapists have practiced by referral. A referral should include a medical diagnosis and an order signed by a physician. In the majority of referrals physicians provide only a general symptom such as low back pain, shoulder pain, or leg problems. During a survey of Kansas physical therapists, we've obtained reports of anywhere from 50 to 80% of the orders read "evaluate and treat as indicated". In greater than 95% of the referred outpatient physical therapy cases, no medical history is provided to the therapist so physicians are already relying on the physical therapist's ability to provide a thorough evaluation to determine the nature and cause of the problem.

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This also requires that the physical therapist take an adequate history to determine indications, goals, and contraindications in the management of the patient. This information is provided to the patient's physician now, and we don't believe physicians will have any less confidence in physical therapist's on-going communication under direct access. The referral which states "evaluate and treat" holds the physical therapist to the same level of professional, legal, and ethical accountability as having direct access without a physicians referral. It seems logical, that if physicians doubt the physical therapist's ability to practice within their scope of knowledge they would write specific and detailed orders/referrals.

Kansas physicians have grown to accept the professional abilities and the growth in physical therapy management and care of their patients. It is evident that for at least 30 years Kansas physicians and physical therapists have developed a mutual respect for each other's expertise in a health care partnership toward effective and safe patient care. Under these conditions, physical therapists have practiced with the same level of professional, legal and ethical accountability as if they had practiced without referral. It is hoped that the explanation just given will help physicians and others acknowledge this, and feel less threatened by something they have supported in every day practice for three decades.

If there truly is a danger in physical therapists practicing without referral it would be evident in looking at

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malpractice claims or judgements as physical therapist are required by law to carry malpractice insurance and pay into the Health Care Stabilization Fund. One can assume that in states with direct access, if physical therapists were not safe to practice without referral, malpractice claims would increase. Maginnis and Associates and Chicago Insurance Company, the nation's largest physical therapy malpractice insurance carriers, verify there have been no increase in malpractice claims, or judgements in the states that have direct access.

5. <u>When physical therapists have the opportunity to practice without a referral will there be any increase in utilization of their services?</u>

Nationally acquired data reported that approximately 10% of the patients are seen without referral in the average physical therapy practice in the states which do not require referral. Therefore, 90% of the cases continue to be seen by a physician first.

This verifies our belief that the overall practice of physical therapy as well as it's utilization will not change dramatically when physical therapists are allowed to practice without referral. However, those consumers who hesitate seeing a physician would be more likely to see a physical therapist and get into the traditional mainstream of medical care instead of going for unregulated and poorly qualified modes of treatment.

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Clearly HB 2113 provides the following benefits.

1. Reduces consumer costs.
2. Provides an opportunity for earlier treatment particularly in rural areas.
3. Provides freedom of choice in selecting bonafided health care professionals and care.
4. Presents no threat to the insurance industry since it would not mandate insurance reimbursement.
5. Poses no threat to hospital physical therapist staffing.
6. Would not mandate physical therapy practice without referral, or preclude a physician, dentist, or podiatrist from making a referral to a physical therapist.
7. Would assist in keeping physical therapist in Kansas and attracting new physical therapist to Kansas.

In my opinion, consumers have a lot to gain from passage of HB 2113. Thank you for your time and I would be happy to answer any questions you might have.

Kansas Physical Therapy Association
KPTA

2201 SW Wilmington Court
Topeka, Kansas 66606

October 15, 1991

Senator Roy Ehrlich, Chrm.
PUBLIC HEALTH COMMITTEE
Route #1, Box 92
Hoisington, Ks. 67544

Dear Senator Ehrlich:

On October 14, 1991, the Kansas Physical Therapy Association Officers, and Legislative steering Committee members working for Direct Access met with Dr. John Lynch, and Dr. Kenneth Gimple, Orthopedic Surgeons in Topeka.

Dr. Lynch and Dr. Gimple, in their capacity as spokespersons for their profession's Direct Access to Physical Therapy Ad Hoc Committee, agreed with the members of the KPTA on the following Amendment to SB 64.

Beginning on page 1, on line 36, the language after "R.P.T." would continue to be stricken. Changes would begin with the italics in the middle of line 40 and be changed to:

Physical Therapy evaluation and treatment may be rendered by a physical therapist with or without referral. If without a referral, treatment may be given for a maximum of 21 calendar days. If the physical therapist determines more treatment is needed, then a consultation with a physician licensed to practice medicine and surgery, a licenses podiatrist or a licensed dentist will be required before treatment is continued.

I am happy to report this progress to you. The KPTA will continue to work with all of the groups who expressed concerns about SB 64 during the hearings last winter. We will keep you informed about our activities and hope SB 64 will receive your committee's favorable consideration early in the 1992 session.

Sincerely,

Frances Kastner

Frances Kastner, Lobbyist
KS. PHYSICAL THERAPY ASSN

PHWO
2-15-93
Attm #9
p. 12 of 47

JOHN A. LYNCH, M.D. 10/15/91

KENNETH GIMPLE, M.D. 10/15/91

Session of 1991

SENATE BILL No. 64

By Committee on Public Health and Welfare

1-28

AN ACT concerning physical therapy; relating to the providing of physical therapy treatment; amending K.S.A. 1990 Supp. 65-2901 and 65-2912 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1990 Supp. 65-2901 is hereby amended to read as follows: 65-2901. ~~(a)~~ As used in this act, the ~~term "physical~~ therapy" means a health specialty concerned with the evaluation, treatment or instruction of human beings to assess, prevent and alleviate physical disability and pain. This includes the administration and evaluation of tests and measurements of bodily functions and structures in aid of treatment; the planning, administration, evaluation and modifications of treatment and instruction, including the use of physical measures, activities and devices for prevention and therapeutic purposes; and the provision of consultative, educational and advisory services for the purpose of reducing the incidence and severity of physical disability and pain. The use of roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the practice of medicine and surgery are not authorized or included under the term "physical therapy" as used in this act.

(b) "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 physical therapist, P.T., Ph. T. or R.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 podiatrist or a licensed dentist in appropriately related cases. Physical therapy evaluation and treatment may be rendered by a physical therapist without referral.~~

(c) "Physical therapist assistant" means a person who works under the direction of a physical therapist, and who assists in the application

following terms and phrases shall have the meanings respectively ascribed to them in this section: (a) "Physical

Physical therapists may evaluate patients and initiate treatment without a physician's order, but shall not continue such treatment for a period exceeding 21 days from the date of initiating treatment unless a physician's order is obtained.

KMS

KANSAS MEDICAL SOCIETY

1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

1/15/92

Jerry Slaughter
Executive Director

Frances,

Here is a copy of some language I drafted to address KMS concerns and honor the 21-day agreement.

See you soon,

Chris

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

PHW 2-15-93 Attach #9 29.15047

of physical therapy, and whose activities require an understanding of physical therapy, but do not require professional or advanced training in the anatomical, biological and physical sciences involved in the practice of physical therapy. 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 assistant, and may designate or describe oneself as a physical therapist assistant, certified physical therapist assistant, P.T.A., C.P.T.A. or P.T. Asst.

Sec. 2. K.S.A. 1990 Supp. 65-2912 is hereby amended to read as follows: 65-2912. (a) The board may refuse to grant a certificate of registration to any physical therapist or a certificate to any physical therapist assistant, or may suspend or revoke the registration of any registered physical therapist or certificate of any certified physical therapist assistant for any of the following grounds:

(1) Addiction to or distribution of intoxicating liquors or drugs for other than lawful purposes;

(2) conviction of a felony if the board determines, after investigation, that the physical therapist or physical therapist assistant has not been sufficiently rehabilitated to warrant the public trust;

(3) obtaining or attempting to obtain registration or certification by fraud or deception;

(4) finding by a court of competent jurisdiction that the physical therapist or physical therapist assistant is a disabled person and has not thereafter been restored to legal capacity;

(5) unprofessional conduct;

(6) the treatment or attempt to treat ailments or other health conditions of human beings other than by physical therapy and as authorized by this act;

(7) failure to refer patients to other health care providers if symptoms are present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the scope of knowledge of the registered physical therapist; ~~and~~

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

~~(9)~~ (8) knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement.

(b) All proceedings pursuant to this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act and shall be reviewable in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. 3. K.S.A. 1990 Supp. 65-2901 and 65-2912 are hereby repealed.

(d) "Physician" means a person licensed to practice medicine and surgery in this state.

a physician or

(8) continuing physical therapy treatment of a patient for more than 21 days without obtaining a physician's order for such treatment;

(9) referring a patient to another physical therapist for continued treatment without a physician's order;

(10) directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations;

(11) advertising or otherwise promoting oneself or a physical therapy practice in a manner which implies the practice of medicine and surgery or other services outside the scope of physical therapy; and

(12)

JHN A. LYNCH, M.D.
PHILLIP L. BAKER, M.D.
RICHARD E. POLLY, M.D.

PETER S. LEPSE, M.D.
BRETT E. WALLACE, M.D.
JOSEPH E. MUMFORD, M.D.

ORTHOPEDIC ASSOCIATES, P. A.

909 MULVANE TOPEKA, KANSAS 66606 1-913-357-0301 1-800-332-0016

November 18, 1992

Candy Bahner, President
Kansas Physical Therapists Association
1237 Bell Terrace
Topeka, Kansas 66604

Dear Candy:

I'm writing to update you on the actions of the Kansas Orthopedics Society at its meeting last month in Topeka. As we discussed, we discussed the issue of direct access to physical therapists. I reviewed for our membership the actions taken by the Kansas Orthopedic Society, and the subsequent actions taken by the Kansas Medical Society. After due discussion, it was decided to endorse the final Kansas Medical Society motion which endorses a ten day period of direct access.

Sincerely,

Peter S. Lepse, M.D.

PSL:kw-g

PHNW
2-15-93
HM #93
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KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 11, 1993

Candice Bahner
104 Olive
Belvue, Kansas 66407

Dear Candy:

In response to your request for our position on the physical therapy "direct access" legislation, I am happy to outline the policy adopted by our Council.

In general, the Kansas Medical Society cannot embrace the concept of "direct access." We believe the current system which requires a physician's order prior to initiating treatment, serves the important dual function of assuring quality care and discouraging overutilization by providing that services are rendered only when medically necessary. However, we recognize that the Legislature may choose to enact a direct access bill. If that happens, our Council believes that such legislation, for the reasons outlined above, should not exceed a 10 day limit on physical therapist initiated treatment without a physician's order.

I hope this addresses your request satisfactorily. If you have any questions, please give me a call.

Sincerely yours,

Jerry Slaughter
Executive Director

JS:ns

PHW
2-15-93
Attm #3
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January 14, 1991

TO WHOM IT MAY CONCERN:

I am writing to make known the difficulty that I have had in obtaining appropriate treatment for a cervical injury that I received July 11, 1988, in a motor vehicle accident. On that date, I was hit from behind by a delivery van. My first step was to go to a minor emergency clinic. At this clinic, I was not offered significant medical help, and it was suggested to me that I look into the services of an orthopedist. I then contacted an orthopedist who was recommended to me, and was told that it would take three months to get an appointment with this physician. Since I had extreme cervical discomfort and was in too much pain to wait this length of time, I chose a different orthopedist and saw this doctor three weeks post injury. This was the soonest I could get in to see an orthopedic physician following my injury. This physician ran some X-rays and then sent me to his own physical therapy department. I was treated there for six weeks by one of his personnel, who I was led to believe was a physical therapist. Later I found out that this was not the case, and this was not a degreed person taking care of my injury. During the first six weeks that I spent at this doctor's physical therapy program, I was treated with moist heat, electrical stimulation, and occasionally interferential electrical stimulation. I was taught no exercises, nor was I given an evaluation, or treated in a hands-on manner in any fashion. After six weeks, there was no improvement in my condition, and I contacted my first doctor of choice again. Again, I was told that I could have an appointment that would be three months from the time I called. Due to rescheduling, both on my part and on the part of this physician, it was actually seven months after the accident before I was able to be seen by this physician. By this time, my condition had worsened. I could not turn my head to either side, I was in pain constantly, I had symptoms of headaches and numbness in my upper extremities, and rather severe pain down the left shoulder blade. I finally got an appointment to see this orthopedist of choice and some testing was done. He ordered physical therapy for me at an independent clinic. It was there that I received my first full physical therapy evaluation. At that time, range of motion deficits were identified and documented. At the time I initiated this physical therapy, my condition had worsened to the point that even light touch on the skin in my neck area was very uncomfortable and several weeks had to be spent desensitizing the neck so that I could receive the treatment. I was told by the therapist in this clinic that I did have a problem with the way my vertebrae were moving, and treatments were directed to correct this. I noticed, at that time, an immediate improvement in my symptoms, and week to week I

PHN
2-15-93
Atm # 3
Pg. 1 of 4 T

could tell that I was getting better. I was given exercises to do at home as well as in the clinic. I was treated in this clinic with modalities for approximately 20-30 minutes and this was followed by hands-on time one on one with the physical therapist for approximately 20 minutes each time I went to this clinic. I was treated with passive stretching, myofascial release, manual resisted exercises, and when appropriate, I did start exercises in the gym in which I exercised for about one hour. Overall, my condition improved. I have been able to gradually perform my household activities and take care of my children. At the present time, I have plateaued in my symptomatic relief with this physical therapy. This physical therapist has also coordinated other medical treatments for me. Once I plateaued and the physical therapy was not benefitting me, she did help me find other specialists who may be of benefit.

Secondary to so much time being spent at the first orthopedist's office with no improvement, the validity of my complaints became questioned by the insurance company. Secondary to my questionable credibility as a truly injured person needing help, I have had a difficult time getting several of the services I require reimbursed by my insurance company, thus my entire medical process has been slowed down. I am currently being seen by a third orthopedist, whose specialty is in difficult back and neck problems and will soon be scheduled to have some injections performed, which may help decrease my pain levels. It is my orthopedist's opinion that I may have progressed in a much more favorable way had my problem been identified and treated appropriately from the beginning. In the area that I live in there is a shortage of qualified physicians to treat problems such as mine. This is a very difficult situation for a patient who has a problem such as this and requires medical attention. When your pain levels are high enough that you feel that you can not wait, you often have to take your second choice, which is, as I have found out, not adequate. If I had been able to see the physical therapist first and have them coordinate my medical treatment, I could have gotten in to see my orthopedist of choice much more quickly and the outcome of my rehabilitation may have been quite different and more favorable. Currently, I still have quite a bit of medical expense and treatment to go through to see if there is anything that will benefit my condition. I have found myself unable to work since this incident. Although I have improved tremendously with the physical therapy program, it will always be in my mind that I might possibly have far surpassed what I am doing right now if I had received the proper treatment at the time of the incident rather than allowing seven months to go by. Arthritic changes, muscular problems, and adaptive shortening occurred secondary to the long time I went with inadequate cervical and head range of motion. Because of this experience, I have become intensely aware of physician referral for profit. I feel like I was kept at the first physician's office strictly for profit, not for the benefits of my health. I

was treated there for seven months with no improvement and no change in my treatment program; I was led to believe that I saw a therapist, which I did not; and that at no point did anyone seem overly concerned with my progress. In fact, I felt like I was not living up to their standards when I did not progress. I would be greatly in favor of direct access for physical therapy, as once I saw an appropriate physical therapist, the dysfunctions in my neck were addressed, my loss of range of motion was addressed, and my pain was consequently decreased. When I plateaued, I was not made to feel like I was failing their system, but that additional help beyond the physical therapist's capabilities were needed. My physical therapist helped me get the appropriate attention from the appropriate people. My physical therapist worked directly with my doctor and kept in direct communication on a monthly or 6-week basis through progress reports. I felt that, at that time, I was getting good comprehensive care, both from this second orthopedist and from my physical therapy program.

I hope this letter will enlighten you to some of the problems we, as consumers, face when we are injured. We now enter an area that we are not trained in and we are basically at the mercy of whoever we see. Having an injury such as mine and the hopeless feelings that you get when you do not progress, as under the first set of circumstances I found myself in, can be very frustrating and frightening. Changes need to be made in our medical system so that this circumstance is kept to a minimum. I felt that I had no immediate choice in my medical care and had to wait the seven months to see the physician of choice secondary to this poor system.

Thank you for your attention in this matter.

Beverly Phelps

FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY

P.O. Box 74
Montgomery, AL 36101-0074
(205) 834-2621

February 3, 1992

Mr. Larry Buening
Kansas State Board of Healing Arts
235 South Topeka Blvd.
Topeka, KS 66603

Dear Mr. Buening:

I have reviewed the Federation of State Boards of Physical Therapy's records dating back to 1986 and have found that there has been no legal action taken against a registration or license of a physical therapist that would indicate inappropriate professional actions regarding mistreatment due to any direct access to the public.

If you need further information regarding this matter, please do not hesitate to contact me.

Sincerely,

Randolph P. Reaves

Randolph P. Reaves
Exec. Officer and Gen. Counsel

RPR/lf

cc: Frances Casener

PH&N
2-15-93
Attn #93
PG. 21 of 47

FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY
P.O. Box 74
Montgomery, AL 36101-0074
(205) 834-2621

December 26, 1990

Ms. Janice Brannon
Assistant Director for
State Relations
American Physical Therapy Association
1111 North Fairfax Street
Alexandria, VA 22314

Dear Ms. Brannon:

Please be advised that I am the Executive Officer and General Counsel for the Federation of State Boards of Physical Therapy. In this position, I routinely review reports from the various jurisdictions throughout the United States regarding disciplinary actions taken by boards against physical therapists and physical therapist assistants. I also review relevant publications, such as Specialty Law Digest Health Care Cases, The Professional Licensing News, Health Week, and other newsletters and journals. Consequently, I'm certain that I'm up to date on professional discipline and malpractice in the field of physical therapy.

I am generally aware of the states which have passed legislation providing for direct access to physical therapy services. I cannot detect any difference in the disciplinary actions or malpractice cases reported from "direct access" jurisdictions, as compared with those jurisdictions that have not passed such legislation. The types of disciplinary actions that I see do not in my opinion have any relationship to direct access whatsoever. I trust that this information will be useful to your organization. If I can be of further assistance, please do not hesitate to call or write.

Sincerely,

Randolph P. Reaves

Randolph P. Reaves
Exec. Officer and Gen. Counsel

RPR/lf

PHNU
2-15-93
Attn #93
PS. 22047

GARY L. HARBIN, M.D., P.A. AND JERYL G. FULLEN, M.D.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY
523 SOUTH SANTA FE
SALINA, KANSAS 67401

TELEPHONE: 913-823-7213

February 5, 1992

Senator Roy Ehrlich, Chairman
Senate Public Health and Welfare Committee
Kansas State House
Topeka, KS 66612

Dear Senator:

This is a letter indicating my support for physical therapists being able to initially evaluate and treat patients for a limited period of time.

I feel that it would enhance the overall quality of medicine and ability of individuals to be able to obtain medical care if direct intervention by the physical therapist can be utilized. Again, I would support that if after a certain number of visits or a certain period of time, the patients have not responded, then they should seek medical care.

At the same time, I would also seek that the same intervention rule apply to chiropractors, and if after a certain period of time or a certain number of visits, the individual is still having difficulty, then they must be referred to an Medical Doctor.

Sincerely,

Gary L. Harbin, MD

GLH/met

PHHN
2-15-93
Attm# 3
Pg. 23 of 47

KENTUCKY STATE BOARD OF PHYSICAL THERAPY

The Mall Office Center, 400 Sherburn Lane, Suite 248, Louisville, Kentucky 40207-4215

Executive Secretary
Nancy B. Brinly, P. T.

502/588-4687
(Office and Fax)

February 3, 1992

Mr. Norm Furs
Reviser of Statutes
KANSAS STATE CAPITOL
Topeka, KS 66606

Dear Mr. Furs:

This agency has been asked to provide you with information concerning patients having direct access to physical therapy services in Kentucky. The provision for less restictive access to those services was first made in 1986. Although initial concerns were expressed by some physicians in '86, the Board has not received related complaints in any form from any part of the medical community since that time.

In addition, no notice of a malpractice settlement or judgement, and no complaints have been received by the board concerning a physical therapist who had treated a patient through direct access. The Board receives all complaints directly, and is advised of malpractice settlements or judgements from the Department of Insurance, as well as licensees (mandatory reporting).

I hope that this information will assist the Kansas Legislators in their deliberations concerning direct access to physical therapy services for their constituents.

Sincerely,

Nancy Brinly, P.T.

Nancy Brinly, PT
Executive Secretary

cc: Georgia King, Chairman
Richard Carroll, Assistant Attorney General

PHHW
2-15-93
Attm #3
Pg. 24 of 47

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Eastside Plaza, 1300 S.E. Quince St. • Olympia, Washington 98504-7800

February 3, 1992

Mr. Norm Furse
Reviser of Statutes
Kansas State Capitol
Topeka, KS 66606

Dear Mr. Furse:

I have been asked to provide information with regard to any disciplinary actions taken against physical therapists in the state of Washington since implementation of direct access in 1988.

To date, the Washington State Board of Physical Therapy has taken no disciplinary actions against any licensee for activities associated with direct access which is described as follows:

> **"RCW 18.74.012 Consultation with health care practitioner not required for certain treatments.** Notwithstanding the provisions of RCW 18.74.010(4), a consultation and periodic review by an authorized health care practitioner is not required for treatment of neuromuscular or musculoskeletal conditions: *Provided*, That a physical therapist may only provide treatment utilizing orthoses that support, align, prevent, or correct any structural problems intrinsic to the foot or ankle by referral or consultation from an authorized health care practitioner."

For your reference, I have included a current copy of our Law Relating to Physical Therapy. If you are in need of further information or clarification, please do not hesitate to contact me at (206) 753-3132.

Sincerely,

Carol Neva

Carol Neva, Program Manager
Washington State Board of Physical Therapy

PHNW
2-15-93
Attm #3
Pg. 25 of 47

M LAND
I. ICAL
SERVICES, INC.

The Commerce Center
11500 Cronridge
Suite 100
Owings Mills, MD 21117

May 1, 1992

Brian Rasmussen, PhD.
Director, Department of Reimbursement
American Physical Therapy Association
1111 North Fairfax Street
Alexandria, Virginia 22314-1488

Dear Dr. Rasmussen,

This is in response to your letter of March 13, 1992 to Ms. Carol Marshall, who forwarded your questionnaire to me. I have attempted to answer the questions on the survey; however, Blue Cross & Blue Shield of Maryland does not track utilization of physical therapy services according to referral source. We are not aware of an increase in utilization of physical therapy services as a result of legislation regarding direct access.

If I can be of further assistance, please do not hesitate to call me at (410) 998-4589.

Sincerely,

Lynn Laubach
Utilization Review Analyst
Medical Policy & Professional Utilization Review Department

PHNO
2-15-93
Attm #3
Pg. 26 of 47

M YLAND
ICAL
SERVICES, INC.

10626 York
Cockeysville, MD 21030

January 16, 1991

American Physical Therapy Association
Attn: Janice A. Brannon, Assistant Director
State Relations
1111 North Fairfax Street
Alexandria, Virginia 22314-1488

Dear Ms. Brannon:

In response to your letter dated October 31, 1990 questioning how "Direct Access" laws have affected utilization of physical therapy service in Maryland.

Maryland has had no disciplinary actions against a Physical Therapist as a result of "direct access" since implementation of the law in 1979. In reference to Blue Cross/Blue Shield of Maryland's utilization rates of physical therapy services, I am unaware of any increase in the utilization of physical therapy services as a result of this legislation over the past several years. Blue Cross/Blue Shield of Maryland does not maintain statistical information relating to physician referral versus self referral for these services.

If you have any additional questions, please let me know.

Sincerely,

Joann E. Stivers

Joann E. Stivers, R.N.
Supervisor, Utilization Review/Audit

PHNW
2-15-93
Attm #3
Pg. 27 of 47

A member company of
Interstate National Corporation

Chicago Insurance Company

55 East Monroe Street
Chicago, Illinois 60603
FAX 312/346-5748
312/346-6400

June 3, 1991

Ms. Janice A. Brannon
State Relations
American Physical Therapy Association
1111 North Fairfax Street
Alexandria, Virginia 22314

RE: Direct Access

Dear Ms. Brannon:

As the underwriter of the APTA-sponsored Professional Liability Plan, Chicago Insurance Company (CIC) has been providing professional liability insurance protection to physical therapists for over 20 years.

At APTA's request, we have been carefully monitoring loss experience to determine if there is an increase in losses which could be attributed to Direct Access.

Out of the twenty-five states which have approved Direct Access, only six states have had Direct Access for five or more years, a long enough period for data evaluation to be credible. In those six states there is no indication that Direct Access has had an impact on claims experience.

CIC recognizes and acknowledges that "Direct Access" is one of the most important issues facing physical therapists today. The professional liability coverage underwritten by CIC, and sponsored by APTA, provides coverage for an insured member who performs his/her duties as a physical therapist, as defined by his/her state practice act. This insurance policy recognizes Direct Access in states where such legislation has been passed.

APTA is to be commended for their commitment and dedication in pursuit of Direct Access legislation in all fifty states.

Sincerely,

Doug Boyce

Douglas E. Boyce
Senior Underwriting Executive

PHNJ
2-15-93
AHM #83
PG. 28 of 47

MAGINNIS AND ASSOCIATES

DONALD F. LANG
PRESIDENT AND CEO

July 12, 1990

Mr. Mark Lane, President
Washington State Physical Therapy Assoc.
208 N.W. Rogers
Olympia, WA 98502

RE: Practice Without Referral

Dear Mr. Lane:

Maginnis and Associates has been a major provider of Professional Liability insurance to physical therapists for over 20 years. Many changes have occurred in the delivery of physical therapy services during that period, the most meaningful being direct access or practice without referral. Almost half of the 51 regulatory jurisdictions now provide for direct access.

You might imagine that this change caused considerable concern by our underwriting companies and our firm as well. It has always been our objective to provide quality insurance at the lowest pricing consistent with the exposure of the profession. Many believe that the quality of care received by the patient will be diminished if the physician does not monitor the treatment provided, in which case the incidents of loss or claims against insured therapists would increase in those areas where a direct access is allowed.

We have been closely monitoring loss experience in those States providing for direct access and while our concern still exists to a certain degree, I am pleased to say that we have not noted the anticipated increase in claim frequency and/or severity. There are no guarantees that this favorable condition will continue, however, quite frankly I see no reason why it should not. We are continuing to monitor this situation and should a significant deviation result you may be assured that I would contact you.

PT+10
2-15-93
Attm #83
Pg. 29 of 47

CORPORATE HEADQUARTERS: 332 S. MICHIGAN AVENUE, SUITE 1100, CHICAGO, IL 60604 (312) 427-1441 FAX (312) 427-7847
Branch Offices: Washington, D.C. • Reynoldsburg, Ohio • Sacramento, California

I personally believe that good therapist will utilize all the tools available in the treatment of the patient. In the case of prior treatment by a physician, I believe the therapist would review the medical record prior to treating the patient. There are always bad therapists, as there are bad doctors, insurance people, etc., in which case whether practice without referral was allowed or not, losses will occur.

While this is a brief statement on a most important issue, I believe it accurately addresses the subject. If I can be of further help, please feel free to contact me personally.

Sincerely,

Donald F. Lang

DFL:dd

apta American Physical Therapy Association
1111 North Fairfax Street, Alexandria, Virginia 22314-1488 (703) 684-2782 • FAX (703) 684-7343

March 13, 1991

Allen Wicken, PT
MMC, PT Dept.
22 Bramhall St.
Portland, ME 04102

Dear Allen:

It has been brought to my attention that there is some concern among members of your business and professional community that enactment of direct access legislation is a first step by physical therapists toward the pursuit of mandated benefits. I can tell you, from our national perspective, that in the 24 states that already have direct access laws, this has not been the case nor has it ever been our intent to pursue mandated benefits in this way.

Direct access legislation is purely an attempt to remove a barrier to a needed health service, to help contain health care costs within a state and to recognize the professional training and expertise of licensed physical therapists within their scope of practice. In fact, coverage of physical therapy services by insurers began in the 1960's on a voluntary basis.

I am happy to provide you with this information. If I or any other member of the staff may be of further assistance to you, please do not hesitate to call.

Sincerely,

Francis J. Mallon

Francis J. Mallon, Esq.
Associate Executive Vice President

A·P·T·A BOSTON

PHNO
2-15-93
Attm #93
Pg. 31 of 47

apta American Physical Therapy Association
1111 North Fairfax Street, Alexandria, Virginia 22314-1488 (703) 684-2782 • FAX [illegible] 684-7343

January 22, 1991

Nancy White, PT
Avery & Associates
2946 Sleepy Hollow Road, Suite 1B
Falls Church, Virginia 22044

Dear Nancy,

You have requested whether the Judicial Committee of the American Physical Therapy Association has noted any increase in the number of ethical complaints or violations as a result of the enactment of direct access legislation.

The Judicial Committee's records give no indication nor raise any inference that ethical complaints or violations occur more frequently in states where direct access to physical therapy is legally permitted and practiced than in states where it is not so.

I hope this information is helpful. Please feel free to contact me if you have further questions.

Sincerely,

Frank Mallon

Francis J. Mallon, Esq.
Associate Executive Vice President
Professional Relations

FJM/sr

PHHW
2-15-93
AHM #93
pg. 32 of 47

ANTHONY MINARD
Chairman of The Board

WEST VIRGINIA
BOARD OF PHYSICAL THERAPY

FRANKIE S. CAYTON
Executive Secretary

November 6, 1989

Midland PT
c/o Mindy Morgenstein
1500 Oaklawn Ave.
Cranston, RI 02920

Dear Ms. Morgenstein:

RE: DIRECT ACCESS - WEST VIRGINIA

I am writing in response to your inquiry concerning "direct access" by Physical Therapists in West Virginia.

As of this date I can of assurance relate to you no negative or derogatory situations that have arisen as a result of our Legislature passing the Bill which gave Therapists direct access in their practice of physical therapy.

There have been no malpractice suits, or any legal situations arising within the State that have required our attention. Services administered to patients are not over utilized; and there is definitely cost containment as pertains to patient expense and insurance expense.

All in all, we feel that this has been a step in the right direction all things considered. We have found only positive results as a result of attaining this privilege; the professionals are well pleased and so is the public sector.

If we can be of any further assistance, please feel free to let me know.

Sincerely,

Frankie S. Cayton

Frankie S. Cayton
Exec. Secretary

/f.s.c.

cc: File

PHNW
2-15-93
Attm #93
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State of U[illegible]
DEPARTMENT OF COMMERCE
Division of Occupational & Professional Licensing

Norman H. Bangerter
Governor
David L. Buhler
Executive Director
David E. Robinson
Division Director

Heber M. Wells Building
160 East 300 South / P.O. Box 45802
Salt Lake City, Utah 84145-0802
(801) 530-6628

November 2, 1989

Stephen Morgenstien
Rhode Island Board of Physical Therapy
1500 Oaklawn Avenue
Cranston, RI 02920

Dear Mr. Morgenstien:

The Physical Therapy Practice Act for the State of Utah was amended in 1985. One of the amendments repealed the provision which required that patients be referred by physicians for physical therapy treatments.

Since that change in the law the Division of Occupational & Professional Licensing has not experienced any noticeable increase in complaints or any noticeable increase in malpractice suits resulting from the repeal of that provision.

Sincerely,

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

David B Fairhurst.

David B. Fairhurst, Licensing Coordinator

DF:mr

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The Commonwealth of Massachusetts
Division of Registration
Leverett Saltonstall Building, Government Center
100 Cambridge Street, Boston 02202

MICHAEL S. DUKAKIS
Governor
PAULA W. GOLD
Secretary

January 9, 1990

Mr. Steven Morganstein, PT
Midland Physical Therapy
1500 Oak Lawn Avenue
Cranston, Rhode Island 02920

Dear Mr. Morganstein,

You have inquired about the consequences of direct access that have been felt by the Board of Allied Health Professions here in Massachusetts.

I am pleased to inform you that in seven years, not a single problem or complaint regarding direct access has been brought to the Board's attention.

Furthermore, the responsibilities of direct access appear to have "matured" physical therapists and enhanced standards of practice.

Best wishes to Rhode Island's physical therapists.

Yours truly,

Lucy J. Buckley, PT

Lucy J. Buckley, PT
Chairman
Board of Allied Health Professions

LJB/kw

PHNJ
2-15-93
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Arizona State Board of Physical Therapy Examiners
1645 West Jefferson, Room 410, Phoenix, Arizona 85007
(602) 255-3095

October 30, 1989

Re: Practice Without Referral

To Whom It May Concern:

Arizona House Bill 2266 was signed into law on July 27, 1983. This legislation gave Arizona physical therapists the right to evaluate and treat patients without a physician's referral and prescription.

The Arizona Board of Physical Therapy Examiners has no record of negative comments concerning practice without referral.

Please let me know if I can be of further assistance.

Sincerely,

Patricia Plack

Patricia Plack
Executive Director

PHW
2-5-93
Hm # 3
PS - 36047

State of Maryland
Department of Health and Mental Hygiene
Board of Physical Therapy Examiners
4201 Patterson Avenue Baltimore, Maryland 21215-2299 (301) 764-4713
TTY FOR DEAF: BALTO 383-7555
D.C. METRO 565-0451

October 31, 1989

Mindy Morgenstein
Midland Physical Therapy
1500 Oaklawn Avenue
Cranston, Rhode Island

Dear Ms. Morgenstein:

With reference to your inquiry regarding Maryland law, enclosed find a copy of the cover letter that was sent with the Maryland Physical Therapy Practice Act when the requirement for "practice by referral" was struck effective July 1, 1979. Since then, the Annotated Code has been revised. The Maryland Physical Therapy Practice Act is now entitled Health Occupations Title 13, therefore "Section 604(b)" referred to in the Board's letter is now found in Section 13-101(i) of the enclosed copy of the law.

As a point of information, the amendment to strike practitioner referral from our law was introduced by a physician and neither the Board of Medical Examiners nor the State medical society opposed its passage.

The Board strongly believes that enactment of this legislation has provided the public with an alternative entry into the health care system which is cost effective and one which has not altered or disturbed the relationships between physical therapists and practitioners when referrals are made.

Sincerely,

Charles M. Dilla

Charles M. Dilla, PT
Chairman

CMD/dvk
Enc: Board letter dated 8/16/79
Correspondence with Torrey C. Brown, MD, re interpretation of HB 346
Board's position statement on HB 346
DHMH's position statement on HB 346
HB 346
Health Occupations Title 13

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Nevada State Board of Physical Therapy Examiners

December 4, 1989

Stephen Morgenstein, MS, PT
Legislative Committee
Rhode Island Chapter APTA
Midland PT Group
1500 Oaklawn Ave
Cranston, RI 02920

RE: DIRECT ACCESS TO PHYSICAL THERAPISTS

Dear Mr. Morgenstein:

In response to your letter dated October 31, 1989 the Nevada State Board of Physical Therapy Examiners has not received any complaints related to direct access to physical therapists in the years since the requirement of referral from various disciplines was deleted from our practice act.

If you have further questions about this matter, please contact me at the board office number listed below. I will be happy to assist you in any way I can.

Very truly yours,

Beverly J. Sygitowicz,
Executive Secretary

/bjs

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P. O. Box 81467 • Las Vegas, Nevada 89180-1467 • (702) 876-5535 • (24 Hours)

Janice Brown
f/f
Ken

Orthopaedic Section, APTA, Inc.

505 King Street, Suite 103
La Crosse, Wisconsin 54601-4062
608/784-0910

January 8, 1991

TO: Executive Committee and Practice Affairs Committee

FROM: Practice Affairs Committee, Orthopaedic Section, APTA
Garvice G. Nicholson, P.T., OCS, Chair
William Boissonault, P.T.
Chauncey Farrell, P.T.
Donald Hiltz, P.T.
LTC. Jack W. Briley, P.T.

In December of 1989, the American Academy of Orthopaedic Surgeons ratified the following position statement entitled "Independent Practitioner Status for Physical Therapists."

The American Academy of Orthopaedic Surgeons believes that the best interests of the musculoskeletal patient are served through a process that ensures a thorough initial diagnostic evaluation performed by a licensed physician, with careful referral for ancillary services.

The important role of physical therapy in the treatment of musculoskeletal conditions is enhanced by cooperation among physicians, therapists, and patients. The Academy believes that the omission of a diagnostic consultation with a licensed physician places the patient at an unacceptable risk and threatens the quality of care for musculoskeletal disorders. Physical therapists are not trained in the complex task of medical diagnosis, nor do they have available to them the tests and equipment requisite for comprehensive evaluation; independent physical therapists may thus begin physical therapy with a patient whose underlying disease is critical and warrants immediate medical attention. In cases such as these, forgoing an initial consultation with a physician may delay appropriate treatment or postpone it indefinitely, resulting in a serious erosion of quality of care.

The Academy believes that independent practitioner status for physical therapists may increase health care costs. The mishandling of patient complaints resulting from inadequate diagnosis may contribute to increased and prolonged medical or surgical costs, in addition to costs already incurred for unnecessary or inappropriate physical therapy. In addition, independent practitioner status may lead to an increase in liability insurance premiums for physical therapists, with costs passed on to patients and payers.

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An important position must be realized. The SCOPE in which Physical Therapists' practice their skills does not change with independent practice. For nearly 23 years as a P.T., I and other P.T.'s have received consults from licensed physicians stating "Evaluate and Treat" with unclear diagnoses such as shoulder pain, LBP, or knee pain. This is a very clear indication that licensed physicians have confidence in P.T.'s evaluating and treating musculoskeletal patients without supervision. It is the P.T. that provides the definitive diagnosis of external rotator cuff tendonitis, PVM strain or patellofemoral pain syndrome. With the recent public awareness of physical therapy and the skills they possess and injuries they successfully treat, many patients with simple musculoskeletal injuries want to be seen by Physical Therapists. However, in many states they have to bear the cost of an office call to a physician just to get the consult adding to the total cost of medical care.

Acting as musculoskeletal evaluators, Army P.T.'s have provided extra time for the Orthopaedic Service to concentrate their efforts and time with surgical patients and fracture treatments. Based on the length of time these successful programs have been in existence, the success of physical therapists making accurate identification of musculoskeletal conditions, and the support of the various Orthopaedic Services for P.T.'s to continue to provide this service, the question of independent practice is not the real issue, but lost revenue.

In the Army, the Orthopaedic Service is part of the P.T. Clinic's QA chain making monthly audits of our evaluations. Their only comments are usually in reference to terminology. If there had, at any point in the past 16 years, been any doubt of Physical Therapists' ability to perform independent musculoskeletal evaluation and treatments the Army's program would have been terminated long ago. This is not a professional issue, but one of money.

From: William Boissonault, M.S., P.T.
2800 Chicago Avenue S., Suite 200
Minneapolis, MN 55407

I received and read with interest your memorandum and accompanying document put out by the American Academy of Orthopaedic Surgeons. Their concerns and complaints about the independent status for physical therapists sounds very familiar. We have heard all this rhetoric during our legislative fight for direct access here in Minnesota.

The bottom line regarding all their concerns is that there is absolutely no proof, no published data, that supports any of their concerns. For instance, in the second paragraph of the document the statement says, "The Academy believes that the omission of a diagnostic consultation with a licensed physician places the patient at an unacceptable risk and threatens the quality of care for musculoskeletal disorders." It is my understanding that McGinnis and McGinnis has published information showing that there has been absolutely no increase in the number of malpractice claims against physical therapists in states that have direct access. Their next statement in that paragraph, "Physical therapists are not trained in the complex task of medical diagnosis"; is absolutely true. It is beyond the scope of physical therapy to evaluate and formulate a medical diagnosis, but physical therapists do receive training to screen for the presence of medical disease in a

If indeed patients were being treated in an inappropriate manner, or treatment were delayed, it is inherently obvious that there would be a marked increase in malpractice suits. Aggressive, zealous attorneys would be only too happy to seize upon a situation in which they could profit from alleged inferior care. Orthopaedic surgeons are particularly cognizant of this.

The bottom line is that the dollars and cents issue would clearly show itself if physical therapists were not performing well as "independent practitioners".

From: Chauncey E. Farrell, M.S., P.T.
5533 Summers Lane
Klamath Falls, Oregon 97603

Mr. Farrell questioned the insistence of the Academy's position on a specific medical diagnosis. He cited Spratt et al (Spine Vol. 15, #2, 1990) who stated a precise diagnosis is unknown in 80 - 90% of patients suffering disabling low back pain. Further, Spratt et al showed equivalent quality of reliable information from the physical examinations performed by physician and non-physician examiners.

Mr. Farrell also spoke to the risks in terms of disability and increased costs associated with unnecessary surgeries performed on the lower back. He cited Saal and Saal (Spine Vol. 14, #4, 1989) and Saal et al (Spine Vol. 15, #7, 1989), both studies reporting favorable outcomes with non-operative treatment of lumbar disc problems, a condition once thought to be amenable only to surgery. Mr. Farrell feels that physical therapists are well qualified to examine patients with mechanical musculoskeletal problems and determines their appropriateness for conservative management.

The Orthopaedic Section is interested in the members' concerns and experiences with this issue. Please address your letters to: Orthopaedic Section, APTA.

/slk

cc: Ken Davis, Dept. of Practice, APTA

x:\wp\sharon\garvresp.doc

SILVER STATE PHYSICAL THERAPY

BRUCE BURKHAM, P.T.

3614 LAKESIDE DR. • Suite 100 • RENO, NV. 89509

702 829-7878

March 11, 1991

American Physical Therapy Association
Government Affairs Office
Attn, Janice Brannon
1111 North Fairfax Street
Alexandria, Va. 22314

RE: DIRECT ACCESS

Janice Brannon,

I am writing to forward a letter that a patient had sent to me after being "evaluated without referral" due to his becoming very frustrated with the local physicians. My evaluation lead him to seek a second opinion from a physician more skilled in this patients area of need, & he has now made very good progress and is headed back to full employment.

I would offer this case as an example for those states considering direct access & rather it would be cost effective in the long run. I see very few of my patients without a physicians referral, but those that come in for an evaluation such as Mr Beck, sometimes are well served by the access to a referral that the other treating physician was reluctant to make.

I hope this is of interest to you,

Bruce Burkham P.T.

Bruce Burkham P.T.

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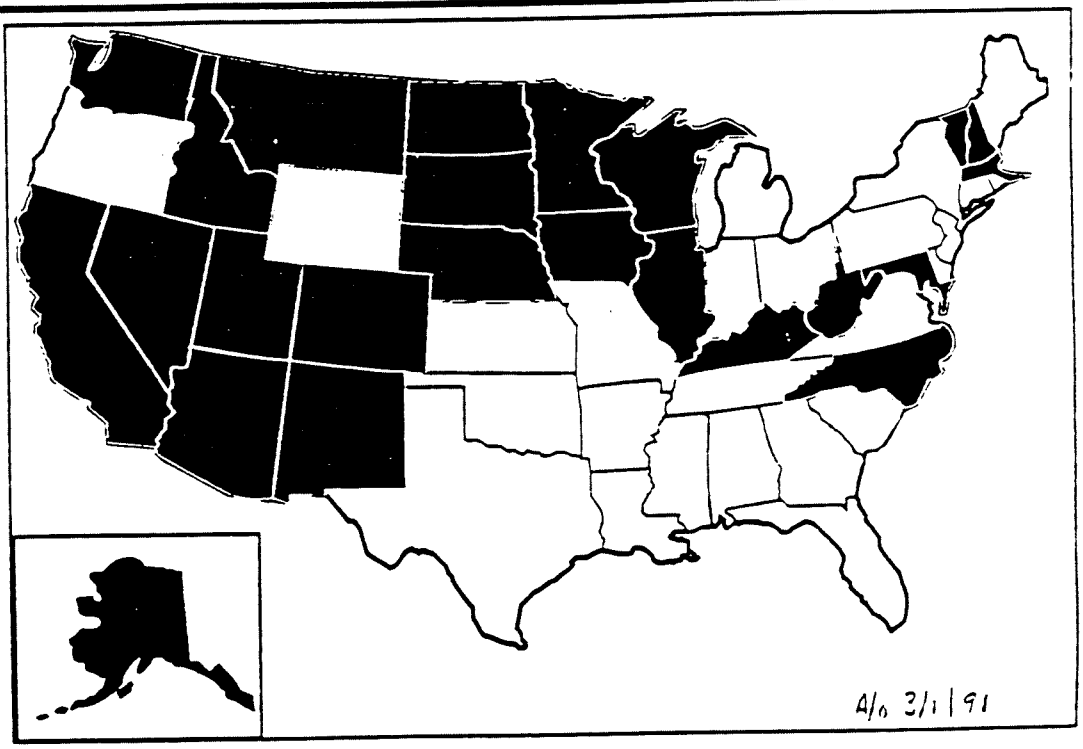
PHYSICAL THERAPY FORUM

shing, Inc.

NORTHEAST EDITION Friday, February 22, 1991

NEWSPAPER



A/o 3/1/91

Physical Therapy Direct Access

By Margaret A. Weir, LPT
and Timothy W. Weir
(Special to the Forum)

Prior to 1968, a physician's referral was necessary for a patient to be treated by a physical therapist. Now, in 24 states, patients have "direct access" to physical therapy.[1] Thus, physical therapists are able to evaluate and treat a patient without a physician's referral. While practice without physician referral is not currently changing practice patterns dramatically, it does eliminate the need for a referral in those situations where a person's condition does not require it. Physical therapists are utilizing direct access in independent practices and are thereby **providing an alternate, more cost-effective entry point into the health care system.**

The cost of health care is continuing to rise and remains a great concern in this country. Americans spent $550 billion on health care in 1988 and have the costliest health care system per capita in the world.[2] If these trends continue, costs will triple by the turn of the century, hitting $1.5 trillion in the year 2000.[3]

While the increase in the cost of health care is due to many factors including inflation, the aging population and expensive new technologies, there is also a belief that increased payment for services by third-party payers is a contributing factor. One reason offered for this increase is the idea that both government and third-party reimbursement systems hold neither the patient nor the health care professional accountable for expenditures.[4] **The challenge, then, is for health care administrators to develop more cost-efficient methods of providing healthcare services to the population.**

Physical therapists who are now operating "independently" or free of physician referral, are proving that the services they

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ATTENTION READERS:

Do you know any PTs currently stationed in the theater of operations in the Persian Gulf? If so, we'd like to hear from you.

Please call the editor at (215) 337-8463.

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Physical Therapy Direct Access

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offer are more cost-effective than services provided by other practitioners. Furthermore, there seems to be no indication that the quality of care received is any less, and actually in some cases may be better, than physician services.

Although almost half the states in the country have direct access services, few insurance companies are reimbursing for physical therapy services unless there is a physician's referral. This is unfortunate for physical therapists who may find it difficult to sustain viable independent practices and, perhaps more importantly, it is unfortunate for the American public who would benefit from the reduced cost of health care through reduced premiums offered by insurance companies. It is our hope to clearly show that third-party payment for direct access physical therapy services may be an effective way to curtail the increasing cost of health care.

Support & Opposition

There is both support for and opposition to direct access to physical therapy. The support comes primarily from physical therapists and the American Physical Therapy Association (APTA) who have worked diligently on obtaining direct access in many states and continue to do so. The opposition is comprised of many physicians, chiropractors, hospital administrators and the American Medical Association (AMA).

Opponents to direct access base their opposition on three primary issues—economics, control and quality of care. Physicians see themselves as losing money if their referral is no longer necessary and believe there is potential for increased health care costs. They also seem to fear a loss of control over serving as the entry point into the health care system. Finally, they argue that physical therapists are not qualified to render the quality of care that physicians can provide.

Economics

As already stated, in states that do not currently have direct access, a physician's referral is necessary prior to a physical therapist's evaluation and treatment. Physicians are concerned that if this referral is no longer necessary, they will lose, at a bare minimum, the fee for an initial visit. For some physicians, the revenue is far greater than simply an initial visit if they employ a physical therapist or physical therapist assistant who is rendering physical therapy services.

"Physiotherapy office visits as a percentage of all physician office visits nationally rose 130% between 1975, 1981, to [illegible] of all office visits," according to the National Center for Health Statistics, U.S. DHHS.[5] Since 1981, "physical therapy" in physicians' offices has continued to grow. This practice has been advocated by physicians who promote the idea that this increases office productivity and thus leads to consumer savings. What the APTA points out is that the potential for patient [illegible] in these situations is quite high. If a physician re[illegible] compensation either directly or indirectly as a resu[illegible] referring a patient to physical therapy, there is an incen[illegible]tive for him/her to refer patients unnecessarily or to refe[illegible] patients for a wider range of services or more freque[illegible] treatments than are actually necessary. In addition, pa[illegible]tients who receive treatment from a physical therapist em[illegible]ployed by a physician may not be encouraged to ade[illegible]quately exercise their freedom of choice in selecting [illegible] physical therapist. (like pharmacies etc.)

It appears that both hospital outpatient units and man[illegible] physicians are trying to gain, financially, by providin[illegible] physical therapy at generally higher rates than those c[illegible] physical therapists in private practice. It has been foun[illegible] that the average charges for private-practice physical the[illegible]apy services are less than if those same services wer[illegible] rendered by a physician or hospital unit.[6] Medicare dat[illegible] including millions of claims for physical therapy/medicin[illegible] in 1985 show that physical therapy charges for all se[illegible]vices averaged 46% *less* than orthopedic surgeons an[illegible] 62% *less* than physiatrists for the same services.[7] A stud[illegible] conducted in 1980 by the Rochester, New York, Blu[illegible] Cross Blue Shield (BCBS) reported similar findings. Th[illegible] data on 14,360 physical therapy claims submitte[illegible] between January, 1978 and June, 1980, revealed that th[illegible] average cost to the patient per treatment was $20 whe[illegible] rendered by a private practice physical therapist, [illegible] 68% *less* than the $62.81 charge for physical t[illegible] services rendered at a hospital outpatient unit.[8]

To further document the potential savings in health car[illegible] costs that third-party payers could achieve, one only ha[illegible] to look at the cost of health care for low back pain. I[illegible] 1977, patients in the United States with low back pai[illegible] made more than ten million visits to physicians and 5-1[illegible] million visits to chiropractors.[9,10] From these statistics, [illegible] is not surprising that the cost of back pain is known to b[illegible] greater than five billion dollars each year.[11] This figure i[illegible] obtained without taking into account the indeterminat[illegible] costs related to workmen's compensation, decreased pro[illegible]ductivity and low wages. "Low back pain is the leadin[illegible] cause of activity limitation for persons under 45 years o[illegible] age and accounts for more than 93 million lost work day[illegible] annually."[12]

(Cont'd on next page

The sole editorial purpose of the PHYSICAL THERAPY FORUM is to provide a forum for the free exchange of ideas and information among practicing physical therapists and PTAs. All types of material are acceptable for publication, including clinical presentations and case studies, anecdotal treatment accounts, objective news items and practical solutions to common problems as well as subjective and thought-provoking essays regarding various aspects of the profession. The main criteria for article acceptance are perceived newsworthiness, utility and/or interest for our readership. The FORUM does not necessarily endorse opinions and information contained in published articles. It is our sincere hope that by initiating discussion on various issu[illegible]d ideas concerning the practice of Physical Therapy, we [illegible]n some small way contribute to the positive advancement o[illegible] profession. Readers are strongly encouraged to express opposing or alternative viewpoints to information appearing in the FORUM, either in writing (articles, letters to the editor, etc.), or by telephoning our editorial office (215-337-8463).

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Physical Therapy Direct Access

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In a monitored program of first contact, non-physician care for patients with low back pain, effectiveness of treatment for back pain by physical therapists was compared to that of physicians. The outcome of low back pain care provided by physical therapists was equal to or better than treatment provided by primary care internists working in a similar setting.[13] Furthermore, the patients managed by physicians were prescribed more muscle relaxants (42% vs. 16%) and more narcotic analgesics (65% vs. 24%) and had more low back pain recurrences (44% vs. 24%) than patients managed by physical therapists.[14] The patients in this study were also found to be more satisfied with all aspects of physical therapy primary care than physician care. The potential savings for third-party payers for physical therapy direct access services is obvious.

Resolution 236 of the *Medical Schools Section Report* in 1989 requested that the AMA "study the implications of patient care without physician diagnosis and referral including the potential for adverse outcomes in patient care and increased health care costs . . ."[15] Studies done on selected health care costs graphically demonstrate that direct access to physical therapy services has not resulted in increased insurance costs.[16] BCBS of Maryland has also found that physical therapy payments have not increased significantly since the advent of direct access in that state in 1979.[17]

While the argument of economics seems flawed for those opposed to direct access, they continue to argue that if direct access is permitted, they are somehow losing control over who enters the health care system. Proponents of direct access feel that direct access would provide an additional entry point into the health care system. This additional entry point into the system may be particularly important in rural areas where health care services are not easily accessible. Additionally, it gives consumers more freedom of choice in selecting a health care professional.

In Indiana, patients who had been treated by physical therapists obviously looked favorably upon their care. A study conducted in 1988 showed that 82.8% of those people who had been exposed to physical therapy in private outpatient settings favored legislation allowing physical therapists to evaluate and treat without a referral.[18]

A final argument posed by opponents of direct access is that injury may result from inappropriate treatment by a physical therapist. In those 24 states that permit direct access, there is no evidence of harm to patients resulting from this legislation. Also, the removal of the referral requirement has caused no negative impact on liability insurance coverage for physical therapists. Maginnis and Associates, a national insurance underwriter for physical therapists, has found that there has been no increase in the occurrence of malpractice claims or judgments. Donald Lang, the president of Maginnis and Associates states, "It would be normal from an underwriter's approach to expect that when a therapist is practicing independently of the physician, claim experience should be less favorable than that where a physician is involved. As this is not the case at the present time, I can only suggest to you that the professional therapist utilizes every viable tool available to provide the patient with the best possible care."[19]

In actual practice, much of the physician control over the provision of physical therapy is largely administrative. Many physicians write referrals that simply state, "evaluate and treat." Many physicians also acknowledge that they have little knowledge of the practice of physical therapy.[20] Recent studies have demonstrated that exercise testing and low back pain treatment can be performed safely and effectively by physical therapists.[21,22]

Proponents of direct access further argue that besides the actual numerical data that can be analyzed, there is further increase in cost savings due to the fact that physical therapy is extensively involved in the teaching of risk prevention and health promotion. Such teaching decreases the risk and incidence of health problems rather than merely treat a problem after it develops. Furthermore, early intervention in the schools and on-site treatment at industries speeds entrance into the health care system resulting in better and more efficient health care.

Current Reimbursement Policies

The current reimbursement policies for direct access physical therapy services are quite simple. Medicare, Medicaid and Workmen's Compensation don't reimburse physical therapy care without a physician's referral. The APTA plans to introduce reimbursement issues to Medicare officials when more than half of the states obtain direct access.[23]

States that permit physical therapists to evaluate and treat without a referral do not require third-party payers to reimburse for such services. Thus, most insurance companies continue to require a physician's referral for reimbursement. Some insurance companies, however, are paying for evaluation and treatment without a physician's referral. These companies include: Aetna, BCBS, Cigna, Equitable, Mutual of Omaha, New York Life, Prudential and Travelers.[24]

Each insurance company sets its own policy on paying for physical therapy without referral. Reimbursement in a hospital setting depends on the individual state's licensing laws as well as on individual hospital policies.

Rationale For and Establishment of a PPO

Direct access has been opposed by hospitals, insurance companies, medical societies and chiropractors. Hospitals fear the loss of revenue and potential loss of employees and medical societies protest under the guise of possible inferior treatment being administered. Chiropractors, who only recently have themselves been given the green light on insurance reimbursement for treatment, clearly stand to

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Physical Therapy Direct Access

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lose revenue. Insurance companies, with the exception of very few, still are reluctant to provide reimbursement for physical therapy diagnosis and treatment without a referral. The reasoning for this appears to be unfounded and financially illogical.

Insurance companies need to bear in mind the growing knowledge of medical care by the public as well as private businesses. Insurance companies are no longer dictating reimbursement policies to industry as they once did. With the majority of the population under age 65 insured through their employer's policy, private industry is now establishing reimbursement levels. Benefit managers and health care coalitions are increasingly examining their costs and demanding more for their money.

An example of the information being gathered illustrates the need to reassess insurance reimbursement for physical therapists. In April, 1983, physical therapists in Arizona obtained direct access. From 1/1/83-8/31/86, BCBS of Arizona analyzed data on 79 procedures performed by various professionals. The results revealed that physical therapists provided the most cost-effective treatment.[25]

Specialty	Annual % Increase Payment
Chiropractor	70%
Hospital	23%
Specialties	33%
Orthopedic Surgeons	20%
Physical Therapist	4%

Additionally, a random national sample showed that direct access did not change payer spending for physical therapy. A 1989 sample of 1125 physical therapy patients found that the average physical therapy private practice charge per episode of care was 2% less in states that permitted direct access when compared to other states.[26]

Presently, many of the state chapters of the APTA have third-party payer committees who contact insurance agencies recommending payment. Often the insurers are encouraged to actively take a role in managing cases and direct patients to the most appropriate health care provider, which is often a physical therapist. In a recent lobbying effort in Minnesota, "physical therapists were not asking to be paid by third-party payers but only for the opportunity to demonstrate that their services are cost-effective and will save insurers money."[27] To satisfy the demands of saving both consumers and insurers money and to give physical therapists an opportunity to prove their competence, I propose the establishment of a preferred provider organization (PPO).

A payer-based PPO would be the method of choice as this is operated by the insurance company. Thus, the insurance company could more expeditiously form contracts with businesses and providers which would help to decrease marketing costs. The areas of specialty encompassed by this PPO would be orthopedics, physiatry, general practice and physical therapy as these areas of medicine are often inter-related. The PPO would be an open model system. This system would allow the enrollees freedom to choose any provider, however the patient would pay less if seen by a provider within the PPO.

The initial step in establishing this PPO is a market analysis of the purchasers. Companies that presently have contracts with the insurance company would be examined in order to give better insight into a successful operation. It would be best to focus primarily on labor-intensive organizations that offer a 80% to 20% reimbursement agreement for employees. This would provide incentives for employers to enroll in the PPO because co-payments and deductibles would be reduced or eliminated. The enrollee would still retain freedom of choice of provider while experiencing less out-of-pocket expenses.

Geographic data would also be analyzed including the age and sex of the residing population in order to determine that an adequate number of people exist to support a PPO.

One of the initial hurdles to overcome in forming this PPO may be physician reluctance, as many physicians and the AMA are opposed to direct access. Because the desire to secure a patient base and increase volume is a lucrative attraction, physicians who respect the expertise of physical therapists may join the PPO for the referral network.

It is not atypical for orthopedists and other practitioners to refer many of their acute, sub-acute and chronic pain patients to physical therapists. Similarly, physical therapists could refer patients to the physiatrist, orthopedist or general practice physician within the PPO if a patient presented to them with a condition that was not within their realm of care. This referral base between physicians and physical therapists would help to keep the patient base within the PPO and would also save the insurance company money.

The primary component of a successful PPO is highly qualified medical caregivers. For physicians' enrollment in this PPO network, several components of their care would need to be assessed: information must be gathered regarding past patient referral rates, procedure use, hospitalization rates, and their willingness to accept varied fee structures. Physicians would be expected to participate in all utilization review requirements and would be required to provide data regarding patient care when requested. Additionally, each physician would be board certified in his/her specialty area.

The PTs enrolled in the PPO would also have to meet certain criteria. It would be required that they have experience of at least six months duration in each of the following areas: orthopedics, work-hardening, general medical-surgical, rehabilitation and cardiopulmonary medicine. A master's and Ph.D. level of education and/or board certification in a specialty area would be preferable. Each therapist would have current licensure and continuing education would be mandatory.

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Physical Therapy Direct Access

(Cont'd from preceding page)

without referral will lead to inefficient and costly patient care. This has been refuted by data on physical therapy charges, liability claims submitted, quality outcome indicators and patient preference polls. This data, although scarce, has been substantial enough to persuade some third-party payers to reimburse direct access physical therapy services.

The responsibility of making third-party payers more aware of the potential benefits of reimbursement for direct access lies, primarily, with physical therapists and the APTA. Cost analysis and research need to be continued so as to further substantiate the facts that physical therapy services are beneficial and cost effective. This responsibility, however, should not lie entirely on this professional group, as they are small in number and do not have the political strength that larger organizations such as the AMA have. Thus, it is the responsibility of those in the insurance industry to implement a managed care system that incorporates reimbursement for direct access.

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States with Direct Access

Alaska	Nebraska
Arizona	New Hampshire
California	New Mexico
Colorado	Nevada
Idaho	North Carolina
Illinois	North Dakota
Iowa	South Dakota
Kentucky	Utah
Maryland	Vermont
Massachusetts	Washington
Minnesota	Wisconsin
Montana	West Virginia

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HB2113

Madame Chairman and members of the House Public Health and Welfare Committee:

I am Jackie Rawlings and I am here to speak in favor of the physical therapy direct access bill. I have been practicing physical therapy for almost 30 years - all in Kansas. As a student at the KU Medical Center in 1963, I helped to get our initial physical therapy practice act passed. In 1983 as President of the Kansas Physical Therapy Association, I assisted in getting our practice act revised to allow evaluation without physician referral. Now 10 years later, I hope that we can again revise our practice act to reflect the way our profession has evolved. Twenty-eight states have already recognized this evolution by allowing direct access to physical therapy, it is working well. There have been no increases in professional liability insurance for physical therapists or any reported incidents related to direct access.

I am here to specifically speak from the standpoint of the hospital based physical therapist. I have always been employed by a hospital. If the direct access bill becomes law, hospital based physical therapists will not automatically be able to utilize it. They must first abide by hospital bylaws. For instance, where I am employed, the hospital bylaws require us to get referrals from non-staff physicians co-signed by a staff physician. It is highly unlikely that our governing board and staff physicians would change the bylaws to allow direct access to physical therapy. However, in smaller, rural communities where all medical services are provided by the hospital and where there is a shortage of physicians, their bylaws could allow direct access to physical therapy. This would allow another less expensive way for the consumer

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to utilize traditional health care. This type of direct access to physical therapy has been allowed in the armed forces hospitals since the mid-seventies.

I have heard concern expressed that if direct access is allowed, physical therapists would leave the hospitals and set up private practice. That is not true. Physical therapists make employment decisions based on many criteria. I work in a hospital because I like the diversity of patients and the contact with the many different medical professionals and services. Some physical therapists choose private practice because they prefer the control and independence it allows. Both private practice and hospital based physical therapists work hard to maintain good rapport with the referring physicians. The working relationships that we have with the physicians will not change with this new legislation. In states where direct access is allowed, physical therapists still rely on physician referrals for 85% of their patients.

Direct access to physical therapy is not a new idea. It is only a less expensive way for the consumer to access physical therapy.

Thank you for your attention and consideration.

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1991

Testimony on SB 664

Keith G. Hauret
Chief, Physical Therapy Clinic
Irwin Army Community Hospital
Ft. Riley, Kansas 66442
(913) 239-7964 (W)
(913) 784-6998 (H)

Mr. Chairman and Members of the Senate Public Health and Welfare Committee:

I am the Chief, Physical Therapy Clinic, Irwin Army Community Hospital, Ft. Riley, Kansas. My experience in physical therapy includes 7 1/2 years as a staff physical therapist, and 5 1/2 years as a chief, physical therapist (clinic director). I am a graduate of the US Army-Baylor Program in Physical Therapy (1976).

As a preface to my testimony, allow me to make clear that the views expressed in this testimony are my own, and do not reflect official policy or position of the Department of the Army, the Department of Defense, or the U.S. Government.

In the Army, physical therapists have performed "primary musculoskeletal evaluations" for more than 16 years. As "primary musculoskeletal evaluators," physical therapists evaluate and treat patients with musculoskeletal pain and dysfunctions, whether or not the patients are referred from a physician, dentist, podiatrist, etc. The majority of patients are either self-referred to physical therapy, or are referred by Physician's

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Assistants who have performed "screening evaluations." The physical therapists review the medical records, evaluate the patients, order radiographs (x-rays) when appropriate, establish treatment programs, and refer patients to other specialty clinics as needed.

The essential point to emphasize is that the physical therapists perform "primary evaluations." Patients have direct access to the physical therapy clinic, wherein the physical therapist will be the first health care provider to evaluate the patient's condition and establish appropriate treatment programs. In these instances, physical therapy has become one of the entry points into the health care system.

There have been many advantages to the Army health care system and to patients as a result of physical therapists fulfilling this role as "primary musculoskeletal evaluators." Among these advantages are:

1. In most cases, patients are afforded quicker and easier access to physical therapy. From experience, this early intervention greatly facilitates the patient's recovery.

2. A greater role in the prevention of further injury is afforded by early intervention, especially in regards to the various types of overuse injuries.

3. Physical therapists have been able to work closely with the various athletic teams on post, as well as with the schools

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on post, to assist the athletes in receiving earlier treatment for their injuries, and to assist in injury prevention.

4. Patients with recurring musculoskeletal conditions greatly appreciate the ability to return directly to physical therapy rather than wait to see their physician to obtain another referral to physical therapy.

These same advantages would be afforded patients if they were allowed "direct access" to "civilian" physical therapy. In addition, there may be a decrease in the cost to patients and insurance companies since the mandatory visit to another health care provider (the physician) would be eliminated. All of these advantages are extremely important in this time of rising health costs.

In actual practice, the role of a "primary musculoskeletal evaluator" is the same as the role physical therapists in Kansas are seeking with "direct access." I am firmly convinced that civilian physical therapists, not only Army physical therapists, are capable of fulfilling this role.

I am in strong agreement with my civilian counterparts in their attempt to amend current Kansas statutes to permit "direct access" to physical therapy services.

Keith G. Hauret

KEITH G. HAURET
MAJ, SP

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The Kansas Rehabilitation Hospital

House Public Health and Welfare Committee

February 15, 1993

Proponent for ~~Senate~~ House Bill # ~~64~~ 2113

Representative Flower and members of the House Public Health and Welfare Committee:

I am Ann Carver, a practicing physical therapist in Topeka. I join with fellow members of the Kansas Physical Therapy Association to request your support of House Bill #2113 which amends Kansas Statutes to permit direct access to physical therapy.

Before I was a physical therapist, I was a yoga instructor. In 1973, I began teaching hatha yoga, or physical yoga, which consists of stretching, breathing exercises and relaxation. Eventually, I started getting students with (1) back pain related to arthritis, disc disease, postural problems, scoliosis and (2) peripheral joint problems such as frozen shoulders or arthritic knees. They began asking me, a yoga instructor, for advice on what they should or should not do. A lot of people are more inclined to ask their yoga or aerobics teacher for advice than to seek help from their physician or another professional in the field. As a yoga instructor, I had no legal restrictions on what I was allowed to recommend. The only restrictions I had were self-imposed.

1504 S.W. 8th Street, Topeka, Kansas 66606
(913) 235-6600

Initially, I had no specialized training in the pathology and treatment of the spine or peripheral joint disease upon which to base my recommendations. There were no required training programs, no testing requirements, or no licensing procedures.

But, I began feeling uncomfortable with the trust these people with serious physical problems had in me, considering the fact I lacked specialized education and training, so I began in 1978 taking courses at Washburn University in anatomy, physiology, kinesiology, etc. and eventually spent two years in graduate school at K.U. Medical Center. I received my Master of Science in Physical Therapy in July 1990.

Now I am employed as a physical therapist at the Kansas Rehabilitation Hospital in Topeka and am a Registered Physical Therapist. The irony of the whole situation, because of the restriction in Kansas law, is that I am more limited as a physical therapist than I was as a yoga teacher. For example, when a patient is assigned to me, I am not allowed, without a physician's referral, to teach him/her the same stretches I utilized when teaching yoga. The patient may have to wait "X" number of days and pay "X" amount of dollars to see a physician before receiving a prescription for physical therapy.

There are a lot of people out there teaching aerobics, yoga, nautilus, weight lifting, and slimnastics in health clubs and community centers telling people with many physical problems what

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to do or not to do. There are no licensing requirements or restrictions for these instructors. Existing law imposes a restriction on state regulated bonafide health care professionals while there are no restrictions on the previously mentioned groups.

Under House Bill #2113, physical therapists would, for the most part, continue to practice with practitioner referral, and communication would continue accordingly. Direct access would only eliminate the need for written referral, not for communication.

Thank you for your consideration. I urge your support of House Bill #2113 and I will be happy to answer any questions you or anyone might have.

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Kansas Physical Therapy Association
KPTA

Testimony on House Bill 2113
February 15, 1993
Steve Chandler, President
Kansas Physical Therapy Association

Madame Chairman and Members of the House Public Health and Welfare Committee:

My name is Steve Chandler. I am currently the President of the Kansas Physical Therapy Association and a practicing physical therapist. I have practiced in the rural communities of Northeast Kansas for 17 years. I am here today in support of House Bill 2113, representative, of the many physical therapists that provide care within our rural communities and other practice settings. I am here to drive home the assertion that the academic and clinical accomplishments of physical therapists today lead to the conclusion that we are, in fact, qualified and prepared to provide a safe, cost effective entry point for patients into the traditional health care system for the care of neuromuscular and musculoskeletal conditions.

Attached to my testimony are letters of support from a hospital administrator and some physicians. One of these physicians is a Board Certified Orthopedic Surgeon. His support for direct access is indicative of other support we have received from within the medical field. His letter relates his respect for our knowledge base of musculoskeletal injuries and their rehabilitation, as well as, the need for immediate care of acute musculoskeletal injuries and our ability to deliver this in a safe and cautious environment. Perhaps most compelling however, is his point concerning the fact that physical therapists are committed to good communication and he feels certain they would consult with him promptly any time a diagnosis was in doubt or the patients condition did not respond appropriately to therapy. His support is greatly appreciated!

In my experience, the support of the physicians I work with as a physical therapist is reflected in their referrals which usually read <u>"Evaluate and Treat, P.T."</u>, or come in the form of a blanket phone referral saying "Do whatever you feel is needed". Due to the high population of elderly which exists in rural areas we often deal with chronic reoccurring musculoskeletal conditions. With current law our patients are told they must obtain a physician's order prior to our initiation of treatment even though it is commonly a reoccurring chronic condition which has been previously treated. Often, when this referral is obtained is simply reads:

15761 Dearborn • Overland Park, Kansas 66223 • (913) 897-7252 • Fax (913) 897-6207

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2-15-93 Attm#7

"Evaluate and Treat as indicated".

It is more rational and cost effective for a physical therapist to perform an evaluation, establish and implement a plan of care, or refer to a physician if conditions are indicative of such. Physical therapists are trained professionals who are capable of determining symptoms that are not appropriate for physical therapy care, or indicate conditions for which treatment is outside our scope of knowledge. We accept our responsibility of patient care, and are committed to the delivery of quality health services.

The physician-therapist relationship which I enjoy is built on an understanding and confidence in the level of expertise each party has. There is a mutual desire to ensure the quality of care for our patients which requires that this confidence in one anothers abilities be justified. The blanket orders I receive, in effect, demonstrate a confidence in my sound judgement in the planning and implementation of physical therapy care for their patients. Likewise, if I contact a physician concerning their patient and advise them of the need for their input or re-evaluation, it receives action. This mutual trust is an important aspect for health care in the rural setting. Direct access would enhance this mutual confidence and, in fact, establish it more firmly.

The primary concern of physical therapy is the identification and the prevention, correction, or alleviation or acute or prolonged neuro-musculoskeletal pain and dysfunction. My profession has an obligation to use our knowledge and skill for the welfare of our patients, and to develop and apply new knowledge in the ever changing health care environment.

Currently, 28 states allow for direct access, including Nebraska and Colorado. In these states it is not mandatory for a physical therapist to practice direct access. He or she may continue to practice in the traditional referral-based type situation and/or choose to practice within the direct access medium. I know this because in addition to my duties in Northeast Kansas, I also practice in Nebraska where direct access has been a part of their Practice Act since 1957.

Does my scope of knowledge increase or diminish just because I cross a state line?

Direct access and referral based practice can and do co-exist! In Nebraska, consumers can and do have an option. For treatment of neuromuscular and musculoskeletal conditions they can directly be seen by a physical therapist for evaluation and treatment, or be seen by their physician. By allowing its consumers the option of direct access, Nebraska provides a valuable mode of treatment while maintaining appropriate safeguards of them.

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In conclusion, direct access does not mean we will no longer accept referrals from physicians, nor does it mean we will be leaving the established medical community.

It does mean a better understanding of roles, more responsibility for the therapist, better communication among all parties, and most importantly better patient care!

Direct Access does not change our scope of practice which will remain within the area of neuromuscular and musculoskeletal conditions.

As to the question of diagnostic accuracy: currently Kansas consumers can seek a wide variety of non-medical care, (e.g. massage therapists, trainers in an athletic club, etc.), for their aches and pains without any initial medical evaluation. Physical therapists, because of their commitment to quality health care and their awareness of their scope of knowledge, would seek medical consultation in an appropriate and timely manner.

House Bill 2113 will allow the consumer in Kansas a more timely, safer, and cost effective way to seek care for an acute neuromuscular or musculoskeletal condition, which is the ultimate goal of direct access.

Thank you for this opportunity to testify. I would be happy to answer any questions at this time.

PHW
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199'

Billy D. Richardson, M.D.

Forest Henney Medical Arts Building
1903 Euclid
Suite 4
Horton, Kansas 66439
Telephone (913) 486-2998

2-4-91

Senate Public Health & Welfare Committee:

Dear Sirs,

This letter is in regard to "Direct Access" to patients of Physical therapists. After long discussions with my local therapist and hospital administrator I have come to the conclusion that "Direct Access" would be a benefit to the community and definately in the best interest of the patient. My experience with physical therapists in the past has been that there is no tendancy to usurp the authority or guidence of physicians. In general, I think their methods are supportive of sound medical care.

In conclusion, I think "Direct Access" to physical therapy services would be a good thing for the state of Kansas and should be considered seriously.

Sincerely,

Billy D. Richardson Jr., M.D.

BDR/lmr

PHHW
2-15-93
Attm #7
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GARY L. HARBIN, M.D., P.A. AND JERYL G. FULLEN, M.D.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY
523 SOUTH SANTA FE
SALINA, KANSAS 67401

TELEPHONE: 913-823-7213

February 5, 1992

Senator Roy Ehrlich, Chairman
Senate Public Health and Welfare Committee
Kansas State House
Topeka, KS 66612

Dear Senator:

This is a letter indicating my support for physical therapists being able to initially evaluate and treat patients for a limited period of time.

I feel that it would enhance the overall quality of medicine and ability of individuals to be able to obtain medical care if direct intervention by the physical therapist can be utilized. Again, I would support that if after a certain number of visits or a certain period of time, the patients have not responded, then they should seek medical care.

At the same time, I would also seek that the same intervention rule apply to chiropractors, and if after a certain period of time or a certain number of visits, the individual is still having difficulty, then they must be referred to an Medical Doctor.

Sincerely,

Gary L. Harbin, MD

GLH/met

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2-15-93
Attm #7
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Atchison Orthopaedics & Sports Medicine

Tom Shriwise, M.D.

1301 N. 2nd St. Atchison, Kansas 66002 367-1023

February 12, 1993

To Whom It Concerns:

Re: House Bill 2113

As an introduction, I am a board certified Orthopaedic Surgeon who has been practicing in Atchison, Kansas for the past 5 1/2 years. I did some extended training in a one year fellowship at the University of Toronto and 6 months of that I was directly involved with sports medicine and sports injuries. During that time, I worked closely with the physical therapists and I gained much more respect for the knowledge base of our physical therapists at that time.

Since practicing in Atchison the past 5 1/2 years, I have worked closely with four physical therapists who are practicing in the immedicate area. During this time, I have been impressed with their knowledge base and occasional suggestions of a need for further workup during their therapy programs when patients were not progressing satisfactory. On several occasions this helped change a diagnosis, which was still evolving or in question. I think it is unfortunate that we have well trained physical therapists who do not have direct access while athletic trainers and many non-medical personnel such as chiropractors and "holistic medicine" personnel do. I think allowing therapists direct access would improve the quality of care throughout our state. This is especially true since we have a shortage of physician caregivers. Since the physical therapists see musculoskeletal injuries and are involved in their rehabilitation on a daily basis, I find that they are as qualified and sometimes more qualified than the lot of trainers, chiropractors, physican assistants, and nurse clinicians that are allowed to see these people directly.

Physical therapists usually have good direct lines of communications with orthopaedics surgeons and if physical therapists are given direct access it may improve the

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immedicate care of any acute musculoskeletal injuries anyway, since patients have difficulty getting into physician offices. If they are given direct access this could actually decrease the cost of medicine to our state, since a large majority of these people may well get better with the initial visit and twenty-one day follow-up allowed by HB 2113. I think our therapists are acutely aware of potential for fracture and missed diagnosis and in my experience they are quite cautious in their care and they are quick to ask for consultation and help when necessary. Please consider passing House Bill 2113 to help improve quality of care to the citizens of our state. Thank you.

Yours truly,

Tom L. Shriwise, M.D.

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Horton Community Hospital

"To promote health and to provide excellent health care services."

February 12, 1993

Kansas House of Representatives
Public Health & Welfare Committee
State Capitol
Topeka, Kansas

Sirs:

As Administrator of Horton Community Hospital, in Horton, Kansas, I am in support of House Bill 2113. It is my understanding that this Bill speaks to direct access for Physical Therapy and, in my opinion, is beneficial to health care access for Kansas residents.

I was in support of the effort last year. I believe that changes have been made in this year's approach as compared to last year that improved the Bill and I believe resolved any questions and differences that arose over the introduction of the issue last year.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Wade H. Edwards
Administrator

WHE/bmc

cc: Steve Chandler, RPT

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2-15-93
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240 W. 18th St. Horton, Kansas 66439 913-486-2642

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

Robert C. Harder, Secretary

Reply to:

TESTIMONY PRESENTED TO

THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2113

Background

This bill would allow a physical therapist to evaluate and provide treatment to an individual for 21 calendar days without a physician's order. Currently, a physical therapist may evaluate an individual for physical therapy services without a physician's order, but must obtain consultation and approval by a physician before initiating the treatment.

Issues

State licensure regulations for hospitals and nursing facilities require that physical therapy services be under the direction of a physician: KAR 28-34-22(a) and KAR 28-39-90(d)(4). Home health agency regulations refer to professional practice acts to determine the necessity for physician authorization of procedures and therapies. KAR 28-51-100(p)

Federal regulations for hospitals, home health agencies and nursing facilities which participate in the Medicare/Medicaid programs require that rehabilitation services be provided under the direction of a physician: 42CFR 482.56(b); 42CFR 484.18(c); and 42CFR 483.45(b). Physical therapists practicing in these settings would be required to obtain physician orders for physical therapy services.

The majority of health care facilities in this state participate in the Medicare/Medicaid programs. Attempts have been made by this agency to bring state licensure in agreement with federal regulations. Should this bill pass, the agency will amend the licensure regulations for hospitals and nursing facilities as appropriate. However, the agency will be obligated to enforce the federal regulations which require physician direction of rehabilitation services in Medicare and/or Medicaid certified hospitals, home health agencies and nursing facilities.

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The intent of this bill is to expand the scope of practice of physical therapists. Allowing the public access to the services of physical therapists without physician involvement outside a health care facility may be appropriate if timely physician contact is impossible and if a clear cut 10 day limitation on such services is provided. Most musculoskeletal injuries will respond to physical therapy within 7 days if it is to be effective at all. Allowing 21 days physical therapy without patient seeing a physician could result in significant overuse of services and, therefore, significant increased cost could cause delayed or missed diagnoses and could deprive the patient of benefit of early medication therapy which often improves care outcome in these cases. The problem for this agency is the conflict between the proposed statute and current federal and state regulations for health care facilities.

Recommendations

Balloon amendment addressing the issues of our testimony is attached for committee consideration. The Department supports passage of HB 2113 with amendments.

Presented by: Patricia A. Maben, Director
Adult Care Home Program
Bureau of Adult and Child Care
Kansas Department of Health and Environment

Date: February 15, 1993

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Session of 1993

HOUSE BILL No. 2113

By Committee on Public Health and Welfare

1-25

AN ACT concerning physical therapy; providing physical therapy treatment; amending K.S.A. 65-2901, 65-2912 and 65-2913 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-2901 is hereby amended to read as follows: 65-2901. ~~(a)~~ As used in this act~~,~~ ~~the term~~*:*

(a) "Physical therapy" means a health specialty concerned with the evaluation, treatment or instruction of human beings to assess, prevent and alleviate physical disability and pain. This includes the administration and evaluation of tests and measurements of bodily functions and structures in aid of treatment; the planning, administration, evaluation and modifications of treatment and instruction, including the use of physical measures, activities and devices for prevention and therapeutic purposes; and the provision of consultative, educational and advisory services for the purpose of reducing the incidence and severity of physical disability and pain. The use of roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the practice of medicine and surgery are not authorized or included under the term "physical therapy" as used in this act.

(b) "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 *person's* 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 physical therapist, P.T., Ph. T. or R.P.T. Physical therapists may evaluate patients ~~without physician referral but may initiate treatment only after consultation with and approval by~~ *and initiate physical therapy treatment without a physician's order, but shall not continue such treatment for a period exceeding ~~21~~ consecutive calendar days from the date of initiating treatment unless an order to continue such treatment is obtained from* a physician licensed to practice medicine and surgery, a licensed podiatrist or a licensed dentist in ,except when otherwise provided by law,

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appropriately related cases.

(c) "Physical therapist assistant" means a person who works under the direction of a physical therapist, and who assists in the application of physical therapy, and whose activities require an understanding of physical therapy, but do not require professional or advanced training in the anatomical, biological and physical sciences involved in the practice of physical therapy. 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 assistant, and may designate or describe oneself as a physical therapist assistant, certified physical therapist assistant, P.T.A., C.P.T.A. or P.T. Asst.

Sec. 2. K.S.A. 65-2912 is hereby amended to read as follows: 65-2912. (a) The board may refuse to grant a certificate of registration to any physical therapist or a certificate to any physical therapist assistant, or may suspend or revoke the registration of any registered physical therapist or certificate of any certified physical therapist assistant for any of the following grounds:

(1) Addiction to or distribution of intoxicating liquors or drugs for other than lawful purposes;

(2) conviction of a felony if the board determines, after investigation, that the physical therapist or physical therapist assistant has not been sufficiently rehabilitated to warrant the public trust;

(3) obtaining or attempting to obtain registration or certification by fraud or deception;

(4) finding by a court of competent jurisdiction that the physical therapist or physical therapist assistant is a disabled person and has not thereafter been restored to legal capacity;

(5) unprofessional conduct;

(6) the treatment or attempt to treat ailments or other health conditions of human beings other than by physical therapy and as authorized by this act;

(7) failure to refer patients to other health care providers if symptoms are present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the scope of knowledge of the registered physical therapist;

(8) ~~initiating treatment without prior consultation and approval by~~ *continuing physical therapy treatment for more than 21 consecutive calendar days from the date of initiating treatment unless an order to continue such treatment is obtained from* a physician licensed to practice medicine and surgery, by a licensed podiatrist or by a licensed dentist; ~~and~~

(9) referring a patient to another physical therapist for continued treatment without an order from a physician licensed to practice

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medicine and surgery, a licensed podiatrist or a licensed dentist;

(10) directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations;

(11) advertising or otherwise promoting oneself or a physical therapy practice in a manner which implies the practice of medicine and surgery or other services outside the scope of physical therapy; and

~~(9)~~ *(12)* knowingly submitting any misleading, deceptive, untrue or fraudulent misrepresentation on a claim form, bill or statement.

(b) All proceedings pursuant to this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act and shall be reviewable in accordance with the act for judicial review and civil enforcement of agency actions.

Sec. 3. K.S.A. 65-2913 is hereby amended to read as follows: 65-2913. (a) Any person who, in any manner, represents oneself as a physical therapist, or who uses in connection with such person's name the words or letters physical therapist, physiotherapist, registered physical therapist, P.T., Ph. T. or R.P.T., or any other letters, words, abbreviations or insignia, indicating or implying that such person is a physical therapist, without a valid existing certificate of registration as a physical therapist issued to such person ~~pursuant to~~ *under* the provisions of this act, shall be guilty of a *class C* misdemeanor.

(b) ~~Any person who successfully meets the requirements of subsection (e) of K.S.A. 65-2906 and amendments thereto shall be known as and designated a physical therapist assistant and may designate or describe oneself as a physical therapist assistant, certified physical therapist assistant, P.T.A., C.P.T.A., or P.T. Asst.~~ *Any person who, in any manner, represents oneself as a physical therapist assistant, or who uses in connection with such person's name the words or letters physical therapist assistant, certified physical therapist assistant, P.T.A., C.P.T.A. or P.T. Asst., or any other letters, words, abbreviations or insignia, indicating or implying that such person is a physical therapist assistant, without a valid existing certificate as a physical therapist assistant issued to such person pursuant to the provisions of this act, shall be guilty of a class C misdemeanor.*

(c) Nothing in this act shall prohibit any person not holding oneself out as a physical therapist or physical therapist assistant from carrying out as an independent practitioner, without prescription or supervision, the therapy or practice for which such person is qual-

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ified, and shall not prohibit such person from using corrective therapy. Nothing in this act shall prohibit any person who assists the physical therapist or physical therapist assistant from being designated as a physical therapy aide.

Sec. 4. K.S.A. 65-2901, 65-2912 and 65-2913 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

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Testimony on HB 2113

Chairman Ehrilch and members of the Senate Public Health and Welfare Committee:

My name is Pauline D. Beatty. I reside in Topeka, Kansas. I have received physical therapy services for several problems in the past. I recognize the benefit and professionalism of physical therapists in Kansas. Because of my personal experience, I also recognize the need for a change in the existing Kansas Statute to allow direct access to primary care; I speak in support of HB 2113.

I refer you to the November 28, 1990 "Report and Recommendations on the Kansas Health Care System" by the Governor's Commission on Health Care. Recommendation #27 under "access to Primary Care", page 26 deals with the very issue that HB 2113 addresses- that of Access to Primary Care. The important issues of savings to the consumer and the practitioner, in both time and money, is also addressed. In simple language, passage of HB 2113 would allow me to contact my physical therapist directly when I am in need of treatment.

While I resent the unnecessary waste of my resources to

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have to go to the doctor for a referral under the present system, I can still survive it. I am fortunate to be ambulatory, in good health, in control of my transportation source and with a good support system. On the other hand consider thoughtfully the circumstances of an older person in need of physical therapy, who perhaps uses a walker, is near poverty-level income, must rely on public transportation, and has no adequate support system. The extra cost to see a doctor before receiving physical therapy increases the inconvenience and the time delay before receiving treatment, which can be a serious burden. All this is in a time of constantly rising living costs plus other real stresses relating to survival. I speak for the hundreds, perhaps thousands, such Kansans with similar case histories who need your help.

I guarantee you this matter relates to the rising cost of medical care to which we must constantly give serious consideration. Why continue such an unnecessary and unproductive practice as now exists? Direct access is the very hear of HB 2113. I urge your support. Thank you for hearing me.

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EXCERPTS FROM PATIENTS' LETTERS REGARDING PHYSICAL THERAPY LEGISLATION

"I requested a Physical Therapist to instruct my son on proper exercises for his back like I received. I was disappointed to learn that the therapists license did not allow this unless my son first was seen by a physician ... this office visit would probably result in a charge of $75 to $100."
Wendell Dickey, Prairie Village

"After experiencing a five month bout of bursitis I heartily endorse a patients right to direct access to physical therapy. My doctor never did recommend physical therapy. I had to ask for it, yet I had to have his approval to begin and continue treatment... In one instance treatment was slowed down because the doctor hadn't taken the time to sign necessary forms."
Betty Swanson, Kansas City

"For the past five weeks I have been a physical therapy patient. Today is the final treatment I can receive without the unnecessary inconvenience and expense of contacting my physician before I can call for more physical therapy. Please consider this a request for your vote for direct access to physical therapy."
Hilda Carlile, Abilene

"After four days of excruciating pain the way was cleared for me to obtain the physical therapy ... care I needed." Louise Heddelston, Chapman

"For many weeks I have needed therapy for Fibromyalgia and continue to need it. Due to regulations, chronic conditions cannot be treated over an extended period of time unless continued improvement can be shown. Some conditions do not "get well" but under skillful hands can be made more tolerable. For chronic conditions direct access to physical therapists could not only expedite care but relieve the patient sooner." Marjorie Martin, Herington

"I was going to a ... rehabilitation agency ... through Workmans' Compensation. I no longer deal with Workmans' Compensation but still have terrible discomfort from injuries. I've wished a million times I could go back to the therapists for help. With this bill it would make it possible to do so."
Beverly Allen, Kansas City

"Both my husband and I support the bill that would allow us to go to a physical therapist without the usual waiting. My husband had to wait over two weeks before he could get some relief from shoulder pain, which at times was agonizing." Mrs. Mercedes Alcala, Topeka

"My wife had a stroke in 1983 and has had four more since then. Each time, in order to get physical therapy we have to go to the doctor for a prescription for the therapy. The doctor asks very little since that is not his line of work. Each time to get a physical therapy prescription we pay $20 to $35 for a doctor office call. That might not be much money to some but it is to a retired firefighter. Please consider this bill." Leslie Dean, Edwardsville

"The delays I encountered when I came directly to a physical therapist with a severe muscle pull, due to the necessity to contact my doctor, seemed unnecessary. I have been on the board of a local hospital for 15 years... The professionalism of the physical therapists is beyond question. I would prefer to be able to use their services without the delays caused by contacting my physician." Dean Dennington, Topeka

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Susan Hanrahan (Written only)

The
Wichita
State University
Department of Physical Therapy

Testimony on HB 2113

Written by:
Susan Hanrahan, PT, PhD
Director, Physical Therapy
The Wichita State University
Wichita, KS 67260-0043
316-689-3604

Madame Chairman and members of the Public Health and Welfare Committee:

This testimony is in support of HB 2113. The University of Kansas and The Wichita State University have the only two physical therapy educational programs in the State of Kansas. This testimony represents both programs and discusses didactic and clinical components of physical therapy education.

Attached as appendices are prerequisite requirements for admission to the WSU physical therapy program as well as the two year professional curriculum. Materials from the University of Kansas would be quite similar. Within the last five years, a baccalaureate degree has been required to enter the physical therapy program. Many educational institutions across the country redesigned their curriculums to a master's entry-level program to prepare physical therapists to deal effectively with the changing health care needs of the 1990's and beyond. Such changes include advances in medical science and technology, the shift of care from inpatient to ambulatory settings and the aging of the population. As a result of scientific, technological and cultural changes,

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physical therapists now treat patients who have increasingly complex pathologic, neurologic, musculoskeletal and sociocultural problems.

Today's physical therapy graduate is a clinician with a focus on evaluation skills, an educator, an administrator, a community consultant and a researcher. Practitioners not only apply practice skills but also make clinical judgements or decisions in situations where there are no rules or guidelines to follow. The clinical generalist in physical therapy is expected to be competent in diagnosing movement dysfunction and in creating and carrying out a plan of care designed to eliminate, alleviate or minimize the identified dysfunction.

Besides skill in evaluation and treatment of motor function, our curriculum provides students the opportunity to be prepared with skills needed to respond to future population needs in a cost-effective way. Prevention of musculoskeletal conditions through primary screening or early detection reduces or eliminates costs that would be associated with long term care.

Students are also taught to work collaboratively with professional colleagues and to effectively refer to, delegate to and supervise appropriate practitioners. With the wealth of qualified health practitioners that exist, it is imperative that all health professionals recognize and utilize each other's area of expertise in the best interest of their patients.

Physical therapy programs in Kansas are accredited by the Commission on Accreditation of the American Physical Therapy Association. Upon graduation, individuals must pass an examination

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administered by the Board of Healing Arts and meet other eligibility requirements to practice in Kansas. Programs in Kansas graduate over 50 practitioners yearly with a nearly 100% pass rate on the state licensing examination and a 100% graduate placement rate in a wide variety of clinical settings.

Most of our students come from other academic institutions in Kansas and are native Kansans, yet our graduate placement attrition rate to other states is 50%. Kansas physical therapy students have indicated that direct access to physical therapy services is a factor in determining where they will work after graduation. Currently, Kansas has physical therapy openings in over 100 clinical facilities.

In conclusion, our goal in education is to develop a graduate who is capable of providing a means of entry into the health care system and providing excellence in physical therapy care. This graduate also recognizes that interdependence of health care professions provides better access as well as more effective and efficient health care for all individuals. The purpose of HB 2113 is to allow patients to make the best use of those services.

Thank you for the opportunity to present information. I am always available to answer questions about the practice of physical therapy.

Appendices attached

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THE WICHITA STATE UNIVERSITY
MASTER OF PHYSICAL THERAPY DEGREE PROGRAM
CRITERIA FOR ADMISSION

1. A baccalaureate degree meeting the requirements of the Graduate School. The baccalaureate degree may vary; however, the prerequisite courses listed here must be met.

2. A minimum grade point average of 3.0 in each of the following: last 60 hours of graded undergraduate academic work; required math/science courses; and all prerequisite courses. No grade less than a "C" in any prerequisite course.

3. *Prerequisite Courses:

Basic Skills:
- English Composition - two semesters
- Speech - one semester

Math/Sciences:
- Biology - two semesters with laboratory in courses which lead to a biology major
- Human Anatomy and Physiology with laboratory (8-10 semester hours)
- Chemistry - two semesters with laboratory in courses which lead to a chemistry major
- Physics - two semesters with laboratory
- Math - College Trigonometry or equivalent
- Statistics - one semester
- Computer Science - one semester application course

Humanities
- Ethics - (medical ethics, preferred) one semester
- Other Humanities (Examples: languages, philosophy, religion, history, literature) - 12 semester hours

Social Sciences:
- Psychology - one introductory course
- Sociology - one introductory course
- Other Social Sciences Courses (Examples: anthropology, gerontology, accounting, political science, management, education, human growth and development, or additional psychology and sociology courses) - 12 semester hours

Note: No more than six credit hours may be counted in one area of a social science or humanities department toward fulfillment of the other prerequisite requirements.

Science & math prerequisites must be taken within 10 years of the time of application.

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Recommended Elective Courses:

Exercise Physiology	Motor Learning
Kinesiology	Pharmacology
Embryology	Dietetics and Nutrition

All undergraduate prerequisite coursework must be completed by the end of the spring term before admission into the fall class.

Prerequisite courses need to be taken for a grade. Pass/fail, credit/non-credit or satisfactory/unsatisfactory grades are not acceptable (excluding CLEP, ACT & Advanced Placement).

Students are encouraged to seek advising or review of their transcripts to verify course level. Appointments for advising can be made by calling (316) 689-3617 for a pre-physical therapy advisor.

*Prerequisites are subject to change.

4. Physical Therapy Observation or Work Experience

   Evidence of twenty (20) hours of observation or work in one or more physical therapy settings will be required for admission.

5. Admission to the program is based not only on grades, but also on the Physical Therapy Admission Review Committee's evaluation of application materials submitted.

   Application packets may be requested by writing to:

   Department of Physical Therapy
   The Wichita State University
   1845 Fairmount
   Wichita, KS 67208-1595

   Applications are reviewed from September 1 to March 1 each year on a rolling admissions basis.

   15 hour rule: Applications will be reviewed if the student has a baccalaureate degree and is within 15 semester hours of completing prerequisite requirements.

   Last semester rule: Applications will be reviewed if the student is in his/her last academic semester (excluding summer) of completing his/her degree and is within 15 semester hours of completing prerequisite requirements.

Revised 4/92

THE WICHITA STATE UNIVERSITY

MASTER OF PHYSICAL THERAPY

FIRST YEAR

FALL

HS 700	Gross Anatomy	6 (3R9L)
PT 705	Clinical Medicine I	4 (4R)
PT 710	Principles of Physical Therapy I	5 (3R6L)
PT 712	Research I	1 (1R)

SPRING

HS 720	Neurosciences	3 (3R2L)
PT 715	Seminar I	1 (1R.5L)
PT 722	Research II	1 (1R)
PT 726	Clinical Medicine II	2 (2R)
PT 730	Principles of Physical Therapy II	5 (3R6L)
PT 735	Physical Therapy Theory and Procedures I	4 (2R4L)

SUMMER

PT 800	Clinical Education I	6 (40P)

SECOND YEAR

FALL

PT 810	Principles of Physical Therapy III	4 (2R6L)
PT 815	Physical Therapy Management I	3 (3R)
PT 825	Seminar II	1 (1R.5L)
PT 826	Clinical Medicine III	2 (2R)
PT 835	Physical Therapy Theory and Procedures II	4 (3R2L)
PT 840	Independent Study	1

SPRING

PT 820	Physical Therapy Management II	2 (2R)
PT 830	Principles of Physical Therapy IV	3 (2R2L)
PT 840	Independent Study	1
PT 845	Seminar III	1 (1R.5L)
PT 850	Clinical Education II	6 (40P)

SUMMER

PT 860	Clinical Education III	6 (40P)
PT 870	Clinical Education IV	6 (40P)

Approved 11/92

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Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

February 15, 1993

To: Chairperson Flower and Members, House Public Health Committee

From: Harold Riehm, Executive Director, Kansas Assocaition of Osteopathic Medicine

Subject: Testimony on H.B. 2113

Thank you for this opportunity to express our views on H.B. 2113. We appear today in opposition to the Bill and in support of what we view as a preferred alternative, H.B. 2438.

Osteopathic physicians in Kansas have great professional respect for the physical therapy profession and those who practice it. They are an important part of the health care delivery system of Kansas. Notwithstanding this respect, we have reservations about the proposed change of permitting physical therapists to initiate treatment of a patient without referral from a physician.

KAOM has long supported the role of mid-level practitioners in Kansas, as needed relief for the shortages of physicians in many parts of Kansas. The important feature here, though, we think is the fact that these providers are working under the supervision of a physician. Under what is proposed in H.B. 2113, a physician would not be involved, unless after a referral was made to a physician, after a 21 day period of treatment by the PT.

Essentially, our concerns fall in two categories:

(1) Diagnosis of a patient's illness or ailment is a complex and difficult part of the practice of medicine. There are times when the manifestation of an illness takes a form that makes diagnosis a difficult endeavor. At times, an ailment that may suggest a normal physical therapy modality of treatment, may be caused by something that more complete diagnosis would suggest is not. This is not to state the absence of instances in which PT's could correctly diagnose and proceed to treat. It is to suggest that this is not always the case and that by the nature and extent of their training, physicians are betted suited to perform the diagnosis function.

(2) We think there is another set of issues which is important and should be considered whenever such proposals of this magnitude are sought. They address the cost and the availability of health care delivery in underserved areas in Kansas. Included among these are:

   a. Will the change have an impact on health care costs? Overall? To the patient?

   b. Will it change the location patterns of those practitioners, in this case, physical therapists?

   c. Will it exacerbate the shortage of hospital based physical therapy services in rural areas?

   d. Will it alter the supply/demand of available health care delivery so that it introduces new variables to the effort to recruit more full service physicians?

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Because of these concerns, KAOM has consistently called for this and other extensive changes in the scope of practice of any health care providers, be submitted to the credentialing review process of the Department of Health and Environment. A measure that would have required this was considered, but not endorsed, by the Committee on Health Care decisions for the Nineties in the most recent interim between Sessions.

We conclude with these two observations:

(1) While some states have passed similar proposals, others have not. In some instances, compromises were reached, such as in Texas when treatment by a PT for a recurring illness, is permitted without the patient returning to his or her physician, if it is within a prescribed time.

(2) WE THINK THE PROVISIONS PROPOSED IN H.B. 2438, IS A PREFERRED ALTERNATIVE TO THIS BILL. IT WOULD PERMIT THE KANSAS STATE BOARD OF HEALING ARTS TO ESTABLISH RULES AND REGULATIONS PERTAINING TO PHYSICAL THERAPY TREATMENT WITHOUT REFERRAL.

I will be pleased to respond to questions.

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Attach #1
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KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 15, 1993

TO: House Public Health and Welfare Committee

FROM: Chip Wheelen
KMS Director of Public Affairs

SUBJECT: House Bill 2113 as Introduced

Thank you for the opportunity to express our concerns about the provisions of HB 2113. Some of you may recall that similar legislation has been considered by prior legislatures. The question of "direct access" to physical therapy services has been discussed extensively by the Kansas Medical Society, other professional associations, and the Board of Healing Arts as well as legislators.

As a general rule, physicians believe that before any person should receive physical therapy treatment, that the patient should obtain a differential medical diagnosis to conclusively determine the source of his or her malady. This would most likely involve the use of x-rays or other diagnostic imaging tests. A person who is suffering from a pain in a joint or the back may believe that he or she needs physical therapy treatment, when in fact that person may be suffering from a serious disease. For example, back pain could be caused by a spinal cord tumor and pains in one's joints may be attributable to an arthritic condition. In such cases, physical therapy treatment may not be appropriate and, in fact, could possibly do harm to the patient.

We acknowledge, however, that some patients, although they need a medical diagnosis, will not seek one. Instead, they will pursue alternative health care services and actually expose themselves to potential injury. For that reason, we would suggest that if you choose to report HB 2113 favorably, that the 21-day direct access period be shortened to 10 days, which we believe is the longest time you should consider allowing physical therapists initiate treatment to continue before a physician should be consulted to render a medical diagnosis of the patient's condition. In any event, if the Committee decides to recommend passage of HB 2113, whether the direct access time period is 10 days, 21 days, or any other, we believe it is imperative that the amendatory language contained in section two be retained in the bill. These features were recommended by the KMS to prevent abuse of the direct access time period.

Thank you for the opportunity to comment on HB 2113.

CW:cb

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My name is Dr. James Edwards and I represent the Kansas Chiropractic Association. I would like to thank the committee for the opportunity to speak in opposition to House Bill 2113.

The Kansas Chiropractic Association is opposed to direct access by registered physical therapists. To understand our opposition, it is necessary to understand different types of health care practitioners. Listening to the physical therapist representatives, it would be easy for committee members to misinterpret the type of practitioner they are. I think it is important for committee members to realize that in the state of Kansas there are <u>licensed</u> practitioners and there are <u>registered</u> practitioners. <u>Licensed</u> persons are doctors of osteopathy, doctors of chiropractic and doctors of medicine. Licensees sit on the Kansas State Board of Healing Arts. On the other hand, there is a subclassification called <u>registered</u> practitioners which would be the physical therapists. They are not doctors and they do not sit on the Kansas State Board of Healing Arts. Licensees are doctors who are permitted by law to order lab work, x-rays, and are <u>required</u> to diagnose. Registrants on the other hand can presently only initiate treatment after the approval of a physician. There is a valid reason for this safety feature. Physical therapists can not order blood work, they are not trained in diagnosis and are prohibited by their law from performing x-ray. Please keep in mind the differences between licensees and registrants when you listen to the testimony and when you make decisions regarding this bill.

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Attm# 13

At the present time, the physical therapy law states that a physical therapist "...may initiate treatment after consultation with and approval by a physician..."

The physical therapy law presently does not even require an examination or a medical diagnosis prior to treatment. All a physical therapist has to do is call a doctor and treatment may begin. I suggest to the committee that this is the lowest acceptable standard the Kansas public should be exposed to.

What can possibly be wrong with calling a doctor prior to treatment? Isn't it possible that proper treatment might be delayed under the proposal that is being presented to you? Isn't it possible that a diagnosis is a good thing to obtain before treatment begins?

The Physical Therapy Association is asking you to allow them to do what no licensed doctor can do. They are asking you to give them "free rein" for 21 days. Every licensed doctor must examine a patient and diagnose the patient <u>prior</u> to treatment. The Physical Therapy Association is asking you to let them "guess" for 21 days. I submit to the committee that this proposal is not in the best interest of quality health care.

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The Kansas Chiropractic Association is the only unbiased organization that will testify on this issue. We have no financial motive. Because of a quirk in the present physical

therapy law, doctors of chiropractic cannot refer to physical therapists. We are testifying not because of loss of income. We are testifying because of the quality of care issue. No one should begin any treatment until the patient has been properly examined and diagnosed. I would insist on that for a family member and I insist on that for the general public. I challenge this committee and the interested parties to find one medical text that recommends non-emergency treatment prior to proper examination and diagnosis.

The physical therapists have testified that they perform evaluation and analysis. Please do not be confused. They are not trained in diagnosis and the physical therapy law does not allow them to perform diagnosis. They are registered. In the interest of public safety, only licensed doctors are permitted to diagnose.

The physical therapists have testified that their proposal would result in a savings for the public. But at what cost? How many patients in the years ahead will go without proper care during the 21 days? Will it cost someone's life? Maybe it's statistically insignificant, but it won't be insignificant for that patient or the patient's family. Let's take a common example. Without x-rays and blood tests, there is absolutely no way for a physical therapist to know if low back pain is being caused by bone cancer. Waiting 21 days for proper treatment will only allow the cancer to spread.

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Let me close by explaining the Kansas Chiropractic Association's primary reason for our opposition. At the present time, the physical therapists are telling us and they will tell you tomorrow that spinal manipulation is part of their practice. My testimony tomorrow will explain that spinal manipulation is the act of thrusting into spinal joints. Personally, I can think of few things more dangerous to the public then to have untrained persons thrusting into spinal joints without an x-ray, without a proper examination, and without a diagnosis. If this bill is not amended to exclude physical therapists from performing spinal manipulation, anything less then our fervent opposition would be unethical, it would be a dereliction of our duty and it would be a violation of the public trust.

We urge you to carefully weigh all of the ramifications of both this bill and the manipulation bill that I will be testifying on tomorrow. We urge you to ignore special interest lobbying and instead focus on what best protects the public. If in doubt, we urge you to err on the side of patient safety.

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Attm #13
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MEMORANDUM

TO: The Honorable Joann Flower, Chairperson
House Public Health and Welfare Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 15, 1993

RE: House Bill 2113

Madam Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2113.

Initially, please be advised that my client does not actively get involved in legislative proposals relative to the licensing or regulation of specific health care providers. However, because of a particular concern relative to the broadening of scope that H.B. 2213 may be instituting, we felt it important to bring our concerns to the Committee.

In our review of H.B. 2113, it appears that the requirement that treatment by a physical therapist may only be done after consultation and with approval by a licensed physician is being eliminated and inserted into that is language that would allow a physical therapist to provide treatments without a physician's order for a period not to exceed 21 consecutive calendar days. Our first request of the Committee is that since this bill would eliminate the current law, coupled with the fact that no insurance policies shall deny

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reimbursement or indemnification for any service within the scope of a practice licensed under the Kansas Healing Arts Act, it would seem to us that K.S.A. 40-2248 and K.S.A. 40-2249 would be applicable for the Committee's review. (Copy attached.)

K.S.A. 40-2248 and 40-2249 require that prior to the legislature's consideration of any bill that mandates health insurance coverages a fiscal impact report must be provided to the legislature for its review. Thus, coupling the language in H.B. 2113 and K.S.A. 40-2,101, it would our contention that a fiscal impact report is required to be presented to this Committee.

Next, we also have a concern as to, by virtue of the language contained in H.B. 2113, the bill's effect on managed care programs. For instance, in an HMO situation would this new language preclude the managed care providers from requiring an evaluation by a physician prior to being referred for physical therapy? Again, we are not necessarily contending that is the intent of the bill, but we have some concern that that may ultimately affect managed care policies, and as such, this should be reviewed by the Committee.

Again, we appreciate the opportunity to present testimony to this Committee, and if you have any questions or comments please feel free to contact me.

Respectfully submitted,

William W. Sneed

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(h) The amounts specified in this section apply only to those employers who qualify for tax credits under K.S.A. 1992 Supp. 40-2246.

History: L. 1990, ch. 157, § 6; July 1.

40-2245. Same; part II coverage benefits; employer contributions. (a) Part II coverage shall consist of optional benefits. All such optional benefits shall contain incentives to encourage the employee to utilize intelligently services in a cost effective way and disincentives to discourage noncost effective use of services.

(b) At least one part II option shall reduce the deductible of the part I coverage.

(c) Employers may contribute toward the cost of part II coverage, and may include the cost of part II contributions when calculating tax credits available under this act.

(d) The small employer health benefit plan may establish that certain options shall not be available to an employee who is not covered by a certain other option or options.

History: L. 1990, ch. 157, § 7; July 1.

40-2246. Same; employer income tax credit, computation of amount, reduction of deductions, election to claim, carry forward; no inclusion of employer expenses in employee income; application date. (a) A credit against the taxes otherwise due under the Kansas income tax act shall be allowed to an employer for amounts paid during the taxable year for purposes of this act on behalf of an eligible employee as defined in K.S.A. 1992 Supp. 40-2239 and amendments thereto to provide health insurance or care.

(b) The amount of the credit allowed by subsection (a) shall be $25 per month per eligible covered employee or 50% of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $25 per month per employee or 50% of the total amount paid by the employer during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes may be carried over to the tax in succeeding tax years until the credit is used. The credit shall be applied first to the earliest income years possible.

(d) Any amount of expenses paid by an employer under this act shall not be included as income to the employee for purposes of the Kansas income tax act. If such expenses have been included in federal taxable income of the employee, the amount included shall be subtracted in arriving at state taxable income under the Kansas income tax act.

(e) This section shall apply to all taxable years commencing after December 31, 1991.

History: L. 1990, ch. 157, § 8; July 1.

40-2247. Same; exemption from insurance premium tax. No premium tax shall be due or payable on a health benefit plan established under this act.

History: L. 1990, ch. 157, § 9; July 1.

40-2248. Mandated health benefits; impact report to be submitted prior to legislative consideration. Prior to the legislature's consideration of any bill that mandates health insurance coverage for specific health services, specific diseases, or for certain providers of health care services as part of individual, group or blanket health insurance policies, the person or organization which seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses both the social and financial effects of the proposed mandated coverage. For purposes of this act, mandated health insurance coverage shall include mandated optional benefits. It shall be the duty of the commissioner of insurance to cooperate with, assist and provide information to any person or organization required to submit an impact report under the provisions of this act.

History: L. 1990, ch. 162, § 1; July 1.

40-2249. Same; contents. The report required under K.S.A. 1992 Supp. 40-2248 for

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assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(1) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(2) the extent to which such insurance coverage is already generally available;

(3) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(4) if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(5) the level of public demand for the treatment or service;

(6) the level of public demand for individual or group insurance coverage of the treatment or service;

(7) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(8) the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(1) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(2) the extent to which the proposed coverage might increase the use of the treatment or service;

(3) the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(4) the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

(5) the impact of this coverage on the total cost of health care.

History: L. 1990, ch. 162, § 2; July 1.

40-2250. Insurance coverage to include reimbursement for services performed by advanced registered nurse practitioners in certain counties. Notwithstanding any provision of an individual or group policy or contract for health and accident insurance delivered within the state, whenever such policy or contract shall provide for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas, the insured, or any other person covered by the policy or contract, shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or an advanced registered nurse practitioner. Notwithstanding the foregoing provisions, reimbursement shall not be mandated with respect to services performed by an advanced registered nurse practitioner in Douglas, Johnson, Leavenworth, Sedgwick, Shawnee or Wyandotte county unless at the time such services are performed such county is designated pursuant to K.S.A. 76-375, and amendments thereto, as critically medically underserved or medically underserved in primary care as defined by K.S.A. 76-374, and amendments thereto.

History: L. 1990, ch. 162, § 3; July 1.

40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination. The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans may also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans

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