

Testimony Re: HB 2159
House Health and Human Services Committee
Presented by Daryl Menke, DPT, MCMT
on behalf of the
Kansas Physical Therapy Association
January 23, 2012

PROPONENT – HB 2159

Madame Chair / Distinguished members:

Thank you for the opportunity to speak in support of HB2159 that provides the Kansas public with the right to be able to access the services of a physical therapist without the burden of the antiquated and extraneous costs of obtaining a referral.

My name is Daryl Menke. I am a native Kansan, physical therapist, and constituent. My professional hats vary including Associate Professor in a Physical Therapist Assistant Program at Kansas City Kansas Community College, practitioner in a private physical therapy practice, as well as Secretary and Reimbursement Chair for the Kansas Physical Therapy Association.

Access to and cost containment of health care continues to remain at the forefront, both at the national and local levels. HB 2159 is an opportunity for this Kansas legislative body to move conscientiously and dutifully towards meeting this societal health care need.

The reality of providing the public with the freedom of choice utilizing the process of unrestricted patient self-referral in obtaining services from a licensed physical therapist has been in existence since 1957. Unfortunately, the speculative arguments by the opponents of the Kansas public achieving this reasonable access to cost containment of health care have been based largely on unsubstantiated supposition. In the spirit of collaboration and compromise HB 2159 does not seek full unrestricted patient self-referral but does improve Kansans enhanced freedom of choice with the following: “sending a copy of the patient evaluation to a physician the patient identifies no later than 5 business days after the evaluation is performed”. “As an additional measure, if the patient does not progress with PT treatment, we must secure a referral from a physician in order to treat beyond 45 days.”

The threadbare opposition tactics have consistently been dispelled by authenticated and corroborated data; regrettably, the Kansas public must continue to bear the unsupported arguments you hear from opposition to this positive public health strategy. “Physical therapists do not possess the educational background” “Physical therapists are not adequately trained” “Physical therapist will miss cancer or other medical maladies” “Utilization and costs will escalate”. The irrefutable response to these statements is well documented:

1. Nebraska has had self-referral since 1957, Arizona since 1983 and Colorado since 1988. At the very least, that's 23 years of evidence regarding patient self-referral. In reality, that's over 30 years of case study! In addition, 14 other legislative jurisdictions have confirmed this with the statutory provision of their respective public's freedom of choice utilizing the process of unrestricted patient self-referral in obtaining services from a licensed physical therapist (48.5 million citizens). I can say with certainty that **your colleagues in these jurisdictions would have repealed their respective statutes if public harm were occurring.**
2. **Physical Therapy is an independent body of knowledge with a unique and defined expertise of practice that is statutorily supported in all 50 States through Physical Therapy Practice Acts and is recognized by multiple accrediting and credentialing bodies** (see page 4 of this document). To meet the complexities of societal health care needs, the educational process for physical therapists has evolved to the Doctorate degree.

The Commission on Accreditation in Physical Therapy Education (CAPTE) is the only agency in the United States recognized to accredit education programs for the preparation of physical therapists and is regulated by the U.S. Department of Education. CAPTE reports all accredited physical therapy academic institutions award the Doctorate degree with the exception of 5 programs that are transitioning to the Doctorate degree, which must be completed by 2015. **This level of education aligns with our colleagues in Chiropractic, Dentistry, Optometry, and Podiatry; they, however, do not have the onerous restrictive requirement of referral from a medical physician for performance of their professional services to the public.** In addition, there is no evidence these providers have harmed the public in the absence of the "gatekeeper theory".

3. If Physical therapists that have the statutory ability to evaluate and treat utilizing the patient self-referral process are missing cancer diagnoses or other medical maladies there would be multitudes of documented cases of public harm and increased liability. There is no evidence to support this in Nebraska, Arizona, Colorado and the other afore-mentioned jurisdictions. This is unsubstantiated and has been categorically refuted by **Michael Loughran, President of Healthcare Providers Service Organization (HPSO), a CNA company that provides professional liability coverage for over 85, 000 physical therapy professionals.** On January 26, 2011 Mr. Loughran wrote, "**We currently have no specific underwriting concerns with respect to direct access for physical therapists.**"

Statistics from the National Practitioner Data Bank (see page 5 of this document) have shown no increased trends and this has been addressed in an article entitled **Malpractice by physical therapists: descriptive analysis of reports in the National Practitioner Data Bank public use data file, 1991-2004.**⁽¹⁾ In this article Sandstrom concluded that, "**cumulative physical therapist malpractice incidence in a state was unrelated to public policy related to direct patient access to physical therapy services.**"

As reported in the article Risk Determination for Patients With Direct Access to Physical Therapy in Military Health Care Facilities ⁽²⁾, the treatment of more than 50,000 patients by a Physical Therapist via direct access resulted in no documented incidence of patient injury or suspension / revocation of licensure.

4. *Over-Utilization and cost escalation* fears have been historically and consistently denounced. In 1994 Dr. Jean Mitchell, Georgetown University, and Dr. Gregory de Lissovoy, John Hopkins University, published the report, A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy ⁽³⁾, which evaluated the paid direct access physical therapy claims from 1989 to 1993. According to their results, **“concerns that direct access will result in overutilization of services or will increase costs appears to be unwarranted.”**

In September 2011, Pendergast et al. substantiated these claims in their article, A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. ⁽⁴⁾ **“In summary our findings do not support the assertion that self-referral leads to overuse of care or discontinuity in care, based on a very large population of individuals in a common private health insurance plan with no requirement for PT [physical therapy] referral or prohibition on patient self-referral.”**

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

Your confirmation of HB 2159 affirms the Kansas public’s right to patient self-referral in obtaining services from a licensed Physical Therapist.

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

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

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

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

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

NATIONAL PRACTITIONER DATA BANK (NPDB) (available at : <http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp> . Accessed January 16, 2012)

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

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3. Mitchel JM. de Lissovoy G. A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy. *Phys Ther*. 1997; 77: 10-18.
4. Pendergast J, Kliethermes SA, Freburger JK, Duffy PA. A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy. *Health Services Research*. Published ahead of print September 23, 2011

J Allied Health. 2007 Winter;36(4):201-8.

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

Sandstrom R.

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

Abstract

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

PMID:18293801 [PubMed - indexed for MEDLINE]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18293801> Accessed January 17, 2012

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

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

Abstract

STUDY DESIGN: Nonexperimental, retrospective, descriptive design.

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

BACKGROUND:

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

METHODS AND MEASURES:

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

RESULTS:

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

CONCLUSIONS:

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

PMID:16294989 [PubMed - indexed for MEDLINE]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16294989> Accessed January 17, 2012

Phys Ther. 1997 Jan;77(1):10-8.

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

Mitchell JM, de Lissovoy G.

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

Abstract

BACKGROUND AND PURPOSE:

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

METHODS AND RESULTS:

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

CONCLUSION AND DISCUSSION:

Direct access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes. There are several potential reasons why this may be the case, such as lower severity of the patient's condition, overutilization of services by physicians, and underutilization of services by physical therapists. Concern that direct access will result in overutilization of services or will increase costs appears to be unwarranted.

PMID: 8996459 [PubMed - indexed for MEDLINE]

Available at:

<http://www.ncbi.nlm.nih.gov/pubmed?term=A%20Comparison%20of%20Resource%20Use%20and%20Cost%20in%20Direct%20Access%20Versus%20Physician%20Referral%20Episodes%20of%20Physical%20Therapy> Accessed January 17, 2012

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

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

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

Abstract

OBJECTIVE:

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

DATA SOURCE:

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

STUDY DESIGN:

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

DATA COLLECTION/EXTRACTION:

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

PRINCIPAL FINDINGS:

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

CONCLUSIONS:

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

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PMID: 22092033 [PubMed - as supplied by publisher]

Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22092033> Accessed January 17, 2012