

Direct Access to Physical Therapy in Michigan is Overdue

Kevin C. Patterson¹, Rachel A. Patterson²

¹College of Human Medicine, Michigan State University, Grand Rapids, MI, USA

²College of Health Professions, Grand Valley State University, Grand Rapids, MI, USA

*Corresponding author: Kevin C. Patterson; Patte297@gmail.com

Direct access to physical therapists (PTs), the ability for a patient to seek care from a PT without physician referral, has been contested for many years. The traditional gatekeeper model of access to physical therapy has changed throughout the nation and only two states remain without direct access. Michigan is one of those states, and the state legislature has not advanced direct access legislation despite numerous opportunities over the past 12 years. However, no evidence exists to show that direct access causes harm to patients and the healthcare system and, on the contrary, easy and early access to physical therapy by patients has been shown to improve outcomes and decrease costs of care. Direct access to physical therapy is long overdue in Michigan and should be reconsidered in order to better serve our patients and the healthcare system.

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Physical therapy includes the treatment of musculoskeletal disorders by qualified and specially trained physical therapists (PTs). PTs are experts in the field of rehabilitation, and in part 178 of the Michigan Public Health Code Act 368 of 1978, PTs are defined as engaging in the practice of physical therapy involving ‘... evaluation of, education of, consultation with, or treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability’. However, as the act continues, ‘Practice of physical therapy does not include the identification of underlying medical problems or etiologies, establishment of medical diagnoses, or the prescribing of treatment’.

In the state of Michigan, patients can be referred from MDs, DOs, DDSs, or DPMs for rehabilitation of different disease states after being evaluated by the physicians or physician assistants/nurse practitioners. PTs in Michigan can evaluate, consult, and educate, but cannot treat patients without a prescription for physical therapy from the aforementioned professionals. A prescription for physical therapy can include the diagnosis, mode, frequency, duration, and intensity of treatment. Despite the prescription, professional standards established by the American Physical Therapy Association obligate the PT to also examine the patient, determine the nature or cause of the problem to be

treated, and develop or modify an appropriate treatment plan. Open referrals or prescriptions are used frequently for problems like lower back pain. In this case, the referral or prescription does not specify the direct problem or the care to be provided, but instead states ‘evaluate and treat’. This obligates the PTs to independently determine a diagnosis and develop a treatment plan and recognizes that they are experts in the field.¹ The restriction on direct access is present in two states in the United States; Oklahoma is the only other state besides Michigan that requires patients to have a prescription for physical therapy before a PT can provide any treatment. Over the past few years, the number of states that had exclusive physician referral requirements has dwindled.

Prior to the current 2012–2013 legislative session, four bills have been introduced to the Michigan legislature since 2000 that failed to receive a vote at various stages in the legislative process. The language in previously proposed legislation has ranged from unrestricted direct access to direct access under very limited circumstances. Currently, Senate Bill 0690 (2013) is designed to allow evaluation and treatment by PTs without a physician prescription for 21 days or 10 visits, whichever first occurs. It also adds specific clauses to require a PT to refer a patient to a physician for cases that present with a problem outside the scope of physical therapy practice or that fail to demonstrate reasonable progress. Thirty-two other states have clauses that require physician referral in a situation similar

to either of the two clauses included in SB 0690.² Furthermore, under the current prescription requirement, it is already stated in part 17,284 of the Michigan Public Health Code Act 368 of 1978 that:

(1) A physical therapist shall refer a patient back to the health care professional who issued the prescription for treatment if the physical therapist has reasonable cause to believe that symptoms or conditions are present that require services beyond the scope of practice of physical therapy. (2) A physical therapist shall consult with the health care professional who issued the prescription for treatment if a patient does not show reasonable response to treatment in a time period consistent with the standards of practice as determined by the board.

Therefore, the passage of direct consumer access would not change the manner in which a PT would provide treatment or make decisions about the appropriateness of physical therapy for a given patient. A PT must continually evaluate whether a prescription for PT is appropriate based on the presenting signs and symptoms or whether a referral back to a physician is needed. The current Michigan law promotes collaboration between healthcare professionals, and SB 0690 would preserve this collaboration.

The education of a PT has adapted in order to provide more comprehensive care and, more importantly, to recognize the symptoms of an underlying disease process that is outside the scope of physical therapy. Currently, of the 212 accredited physical therapy programs in the United States, 96% are offered as a Doctor of Physical Therapy (DPT).³ The remaining programs are offered at the Master's level, but will be required to transition to a DPT program to remain accredited. Students receive training in disease processes of musculoskeletal, cardiopulmonary, neuromuscular, integumentary, metabolic/endocrine, gastrointestinal, and genitourinary systems with a commitment to learning evidence-based practices for improving their patient's health. PTs even have subspecialties that delve into specific regions of the body, patient populations, or disease states. PTs have been taught the process of physical diagnosis and history-taking skills, acting in the patient's best interests, leading to better health outcomes.⁴ The training eventually leads to board certification and licensure in the state they choose to practice in (MI Public Health Code 368 of 1978, 333.17820). Licensure for all students also includes passing the National Physical Therapy Exam (NPTE). Because 48 states have some form of direct access, students must possess the knowledge necessary to

practice in a state with direct access to pass the NPTE. Therefore, students who receive an education in Michigan are trained to practice with direct access, yet do not have the right to do so.

Published case reports have demonstrated that PTs consider a broad differential and are able to recognize non-musculoskeletal disorders, leading to referral for medical evaluation and proper management.⁵ In addition, PTs take detailed histories and have excellent physical exam skills.^{4,6} There are multiple published reports of PTs referring patients to physicians through history and physical exam or through inconsistent referral diagnoses which has led to proper evaluation and management.⁷ Both DPTs and physical therapy students scored higher than physicians of multiple specialty types and medical students on exams designed to assess intern physician knowledge of musculoskeletal medicine, and were only outscored by orthopedic specialist physicians,⁸ demonstrating that on a standardized examination, PT students and DPTs have similar if not better musculoskeletal disorder management knowledge than most physician types and medical students. A study of patients being referred to physical therapy by a sample of general practitioners and specialists showed that less than one third of referrals included a specific diagnosis.⁹ Therefore, PTs must use clinical judgment to determine the etiology of the symptoms in order to provide treatment more than may be commonly recognized.¹⁰ Zero adverse events were seen in a large retrospective study of open access to patient care in a multi-center military setting. Even during the analysis of data, a great number of medical diseases were diagnosed by PTs, such as Ewing sarcoma, compartment syndrome, and pelvic masses, leading to proper evaluation and treatment of patients.¹¹

Quick access to PTs was shown to have positive results and was well received among patients. The patients were satisfied and physicians generally preferred quick access.¹² Having a PT consult for patients in an office led to a change in management and even to a decrease in referral to physician specialists. Primary care providers were often satisfied with a very large majority of the consults, demonstrating that PTs can determine physical therapy requirements and favorably change patient management, leading to better health outcomes.¹³ Early access to physical therapy has led to a greater reduction in pain perception.¹⁴ For patients with lower back pain, early referral had decreased likelihood of advanced imaging, additional physician visits, major surgery, spine injections, and opioid prescriptions.¹⁵ Early referral was also shown to decrease cost

of care as did close proximity of physicians to PTs.¹⁵ Although the study did not take into account whether later referrals were a consequence of negative imaging or failed techniques prior to referral, the study only considered outcomes after primary care provider referral and not under direct access.

Opponents of direct access express concern about the loss of physician oversight and control of physical therapy utilization. As reviewed in Donato et al., PT provided under direct access has been shown to be cost effective, and there is often high patient and physician satisfaction with functional improvement with PT management.¹⁶ Empirical data regarding the cost effectiveness of direct access comes from two studies. A 1997 study by Mitchell and deLissovoy studied over 600 Blue Cross Blue Shield of Maryland claims, and found that costs of physical therapy care under direct access resulted in fewer visits and over half of the cost of those episodes that occurred as a result of physician referral.¹⁷ Most recently, a 2011 analysis of over 62,000 Iowa and South Dakota non-Medicare claims data similarly revealed that episodes of physical therapy care under direct access cost less and had fewer visits than those that were referred by a physician.¹⁸ The study was not designed to allow comparison of disease severity or outcomes, so this cannot be inferred, however it gives a general sense of decreased healthcare burden by self-referral. An opponent to direct access may argue that it will increase the costs because patients will have to be referred back to physicians since patients may not know what problems can be fixed by physical therapy. However, in Scotland, Holdsworth et al. studied the costs of self-referral vs. physician-suggested referral vs. physician-referred physical therapy, showing that self-referred patients had less costs associated with the injury/disease state and decreased referrals to specialists, analgesics, and general practitioner visits, all while having similar disease severity.¹⁹ In addition, a study showed that self-referral to physical therapy led to significantly shorter visits to their primary care providers, allowing physicians to focus their attention on other cases.²⁰ Even though direct access has not been shown to increase the cost of healthcare, opponents of direct access continue to express concern about increased costs. During the 2011–2012 legislative session, companion bills were introduced that would have permitted third party payers to continue to require a physician referral despite a regulatory change allowing direct access. Despite these provisions, third party payer groups continued to oppose direct access legislation. Currently, similar

companion legislation (Senate Bills 0691-0694) has been introduced to allow for insurance agencies, corporations/businesses paying for worker's compensation, and others to require a physician prescription as a condition of payment for physical therapy.

In considering the peer-reviewed, published research about direct access to physical therapy, Michiganders should advocate for a change in state law by urging the legislators to pass Senate Bills 0690-0694. The benefits of direct access to physical therapy outweigh the potential harms and unsubstantiated fears associated with it. PTs are very well educated healthcare professionals, with nearly all entry-level PTs obtaining doctorate level degrees. These providers are well qualified and able to take on more patients than primary care physicians can handle. This would not only free up the time that primary care providers may desperately need for other complex issues, but would allow for shortened time to treatment and lower costs of care for many patients.

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