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2 US Hospital-Based Direct Access with Radiology Referral: An Administrative Case Report.

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ABSTRACT:

Background and Purpose: Legislative gains in the United States (US) allow physical therapists to function in expanded scopes of practice including direct access and referral to specialists. The combination of direct access with privileges to order imaging studies directly offers a desirable practice status for many physical therapists, especially musculoskeletal focused settings. Although direct access is legal in all US jurisdictions, institutional-based physical therapy settings have not embraced these practices. Barriers cited to implementing direct access with advanced practice are concerns over medical and administrative opposition, institutional policies, provider qualifications and reimbursement. This administrative case report describes the process taken to allow therapists to see patients without a referral and to order diagnostic imaging studies at an academic medical center. Nine month implementation results show 66 patients seen via direct access with 15% referred for imaging studies. Claims submitted to 20 different insurance providers were reimbursed at 100%. Discussion: While institutional regulations and reimbursement are reported as barriers to direct access, this report highlights the process one academic medical center used to implement direct access and advanced practice radiology referral by updating policies and procedures, identifying advanced competencies, and communicating with necessary stakeholder groups. Favorable reimbursement for services is documented.

50

51 BACKGROUND AND PURPOSE

52 Advanced Practice for non-physician healthcare professionals is of global interest as physician
53 shortages, rising costs, and new models of healthcare delivery provide opportunities for
54 providers to expand traditional scopes of practice in an attempt to provide cost-effective, quality
55 care. Advanced practice is generally described as those roles which involve the use of increased
56 knowledge and skills within a profession (Lowe, Blummer, O'Brien, and Boyd, 2012). In
57 physical therapy, advanced practice is described most frequently as clinical specialization or an
58 expanded scope of practice. Clinical specialization in physical therapy is a formalized process to
59 recognize advanced knowledge and skills in a specified area of practice and is endorsed
60 throughout the world by professional organizations and regulatory boards (World Confederation
61 of Physical Therapy (WCPT), 2011). Expanded scope of practice includes assuming new roles
62 in areas previously controlled or supervised medically such as diagnosis, triage, ordering
63 imaging or laboratory studies, and prescribing or administering pharmaceuticals. Expansion of
64 traditional clinical roles through changes in scope of practice involves regulatory, educational
65 and administrative changes.

66 Studies of advanced practice in physical therapy (APPT) have focused predominantly on
67 musculoskeletal clinics and emergency departments (Desmeules, Toliopolos, Roy, Woodhouse,
68 et al., 2013; Lebeck and Jogodka, 2009). Within the US and abroad professional association
69 position statements and governmental regulatory commissions' reports have emphasized the
70 inclusion of physical therapists as first-contact, autonomous, client-centered professionals whose
71 services include traditional activities as well as advanced practice components including
72 prescribing pharmaceuticals, ordering imaging and laboratory studies, or case management

73 (Health and Care Professions Council, 2012; Canadian Physiotherapy Association, 2012;
74 Australian Physiotherapy Association, 2009; American Physical Therapy Association (APTA),
75 2002). While laws, regulations, and professional policies may allow advanced practice,
76 administrative policies and individual professional competence may limit physical therapists
77 from these privileges.

78 Despite legal authority, institutional restrictions are often present which prohibit PTs from
79 engaging in this higher level of care (Ojha, Snyder, & Davenport, 2014). Within each clinical
80 setting, changes to allow an expanded scope of practice must be implemented including
81 administrative and professional staff approvals, certification of competence, and assurance of
82 reimbursement for services. This administrative case report focuses on the implementation of
83 advanced physical therapy practice including direct access and privileges for direct referral for
84 imaging services in one US academic medical center. This report will review the rationale for
85 advanced practice for physical therapy, the organizational structure of the hospital system, the
86 administrative and medical approval processes, and credentialing for physical therapists.

87 INTRODUCTION:

88 Direct access to physical therapy services has been defined as, “The ability of a health care
89 consumer to freely visit a physical therapist without first securing referral from a physician”
90 (Mitchell and de Lissovoy, 1997). The benefits of direct access have been documented in the
91 literature and include: decreased cost per episode of care, improved short and long-term
92 functional outcomes, reduced sick leave, decreased recurrence of back pain episodes, decreased
93 prescription of muscle relaxants and narcotic analgesics, and significant improvement in patient
94 satisfaction overall (Fritz, Cleland, Speckman, Brennan, et al., 2008; Fuhrmans, 2007; Jette,
95 Ardleigh, Chandler and McShea, 2006; Kelly and Bradway, 1997; Greathouse, Schreck, and

96 Benson, 1994; Linton, Hellsing and Andersson, 1993; Greathouse, Seeney, and Ritchie
97 Hartwick, 1988; James and Stuart, 1975). Primary barriers to implementation of direct access
98 have been cited as local administrative policies and concerns over denials for reimbursement if a
99 physician referral has not initiated care (McCallum and DiAngelis, 2012; APTA, 2010;
100 Boissonnault, Badke, Powers, 2010; Crout, Tweedie and Miller, 1998).

101 Administrative policies in private and non-profit healthcare systems in the US follow
102 accreditation standards allowing patients to only access providers with clinical privileges at that
103 facility and to provide services allowed by licensure regulations. Military hospitals in the US
104 follow federal standards for care which are not bound by state-authorized licensure regulations.
105 Physical therapy direct access advocates in the US have pointed to the military model of
106 musculoskeletal care as a guide to implement direct access through institutional credentialing
107 with identified clinical privileges. The military clinical privileges include direct access, limited
108 pharmaceutical prescriptive authority, authorization to order imaging and laboratory tests, and to
109 restrict activity (Greathouse, Sweeny, and Ritchie Hartwick, 1988). Credentialing for providers
110 in military, private, and non-profit facilities requires verification of the legal right to practice,
111 education, and affiliations with other healthcare organizations. While granting clinical privileges
112 involves identification of the specific services or procedures that an individual may administer
113 within the healthcare institution. The military model is based on the granting of clinical
114 privileges to military physical therapists who have institutional and medical staff approval as
115 well as additional training in differential diagnosis, pharmacology, and medical imaging.

116 The practice privilege approach to securing expanded scope of practice requires the clinician to
117 function within established institutional policies and to collaborate in an inter-professional model

118 with other providers to manage conditions that may fall outside the clinician’s scope of practice.
119 The clinical privilege model of care has proved effective for the US military for over forty years
120 and serves as a model for advanced practice in physical therapy.

121 Additional evidence supporting expanded scope of practice for physical therapists is found
122 across practice settings and countries (WCPT, 2011; Health and Care Professions Council, 2012;
123 Canadian Physiotherapy Association, 2012; Australian Physiotherapy Association, 2009; APTA,
124 2002). Desmeules et al. (2013) in a systematic review including 16 studies found physicians
125 and physical therapists are equally as effective in diagnostic accuracy, intervention effectiveness,
126 resource utilization, and patient satisfaction in musculoskeletal clinics and emergency rooms.
127 James and Stuart (1975) found a 50% reduction in radiological examinations among military
128 physical therapists compared to physicians in a population of over 2,117 patients suffering from
129 low back pain. Boissonault et al. (2010) discussed the implementation of direct referral for plain
130 film x-rays at a group of hospital-based orthopedic clinics. Cost effectiveness and similar level of
131 quality of care compared with referred episodes of care was supported in a systematic review by
132 Ojha, Snyder, and Davenport (2014). Advanced practice and expanded scope of practice for
133 physical therapists are well supported in the literature as safe and effective. Widespread adoption
134 of the expanded practice scope requires deliberate action by physical therapists to overcome the
135 identified challenges to implementation of the changes.

136 CASE DESCRIPTION:

137 Georgetown University Hospital (GUH) is a private, not-for-profit, 600-bed teaching and
138 research hospital located in Washington D.C. GUH, a part of Medstar Health, is a regional
139 healthcare system comprised of 9 hospitals and 20 other health-related businesses in the greater

140 Washington D.C. area. GUH's organizational structure requires administrative approval at
141 multiple levels in order to alter existing system or hospital policies. As a Joint Commission
142 accredited facility, GUH has policies requiring independent health care providers with practice
143 privileges to meet credentialing requirements and be granted specific clinical privileges within
144 the approved scope of practice. When the effort to seek direct access at GUH began, physical
145 therapists were not recognized as independent health care providers with clinical privileges to
146 see patients under direct access or refer to other services. Physical therapists, as employees of the
147 facility, were required to have physician referral prior to patient treatment.

148 The physical medicine and rehabilitation (PM&R) department at GUH employs 42 full time
149 therapists (Occupational, Speech, and Physical Therapy). Fifteen physical therapists staff the
150 adult outpatient clinic (12 full-time, 1 part-time, and 2 per-diem therapists). This clinic sees
151 predominantly an orthopedic case load, but neurological, medical, and cardiopulmonary cases
152 are seen as well. The outpatient team has 7 therapists with board certifications issued through the
153 APTA (3 orthopedic specialists: 1 of whom is dual certified in women's health and orthopedics,
154 2 sports specialists and 2 neurological specialists). Patients range in age from children to senior
155 citizens. An individual therapist may treat between 8-15 patients a day depending on diagnosis
156 and severity of condition. The outpatient PT team is overseen by 2 clinical leaders, an outpatient
157 clinical manager and the Director of PM&R, all of whom are practicing physical therapists.
158 Medical direction is provided by a physician board certified in neurology.

159 Regulatory Authority

160 District of Columbia Department of Health's Board of Physical Therapy (BPT) licenses physical
161 therapists employed at GUH to practice (DC Practice Act, 2011). The District of Columbia has
162 legally allowed physical therapists to function as first contact providers since 2007. (First contact

163 providers are able to see patients for evaluation and treatment without a prior medical diagnosis.
164 Direct access in some US jurisdictions requires a prior medical diagnosis but not referral to a
165 physical therapist.) As is common in many practice acts, the District of Columbia Board of
166 Physical Therapy requires therapists to refer patients to “an appropriate healthcare provider”
167 when the patients’ condition falls outside the PT scope of practice. The responsibility to
168 determine what conditions may fall outside a therapists’ scope of practice is dependent on the
169 therapist's competency in assessing the specific presenting condition, as well as, various tests and
170 measures which may include pharmacotherapeutics and imaging studies. While first contact
171 provider and direct access are a recognized part of the physical therapists' scope of practice in the
172 District of Columbia, referral for imaging studies was not specifically identified as within the
173 scope of practice for physical therapists. Clinical privileges to request imaging studies are
174 important in providing first contact provider care to an orthopedic patient population.

175 Expanding the Scope of Practice

176 GUH physical therapists began an initiative in late 2009 to implement an expanded scope of
177 practice at the facility level which included clinical privileges for first contact and direct access
178 as well as direct referral for imaging. Implementation of this expanded scope of practice required
179 the leadership team to strategically plan for the regulatory, administrative, and provider
180 competency changes that would ensure quality patient care. The PT management team began
181 discussions on implementing the expanded scope of practice with the adult outpatient (OP)
182 therapists. The majority of the OP team was in strong support, although several therapists were
183 unaware of the updated practice act language. Additional concerns were expressed concerning
184 medical staff support and reimbursement for services.

185

186 Regulatory Approval

187 Clarification of the regulatory status of radiological referral was necessary before the advanced
188 practice changes could be sought. The GUH physical therapists sought an opinion from the
189 District of Columbia Board of Physical Therapy, specifically to clarify if physical therapists
190 could refer patients for diagnostic imaging studies. The written opinion received was:

191 “...the Board believes that a physical therapist may refer a patient for diagnostic imaging
192 to a health care provider who is qualified to perform such testing, provided the other
193 conditions as set forth in the regulation (Section 6710.13) are met (DCBPT, personal
194 communication, May 15, 2010).”

195 The written opinion from the licensing board was seen as a critically positive step in moving
196 forward. Following receipt of the opinion, the leadership team made plans to secure hospital
197 administrative approval.

198

199 Administrative Approval:

200 GUH’s organizational structure requires policy changes to be approved by both administrative
201 and medical leadership. With the legality of the initiative confirmed, administrative approval
202 throughout the chain of command was then necessary. Approval at each administrative level
203 above the PT department was required. The PT leadership team drafted an executive summary
204 explaining the rationale for the recommended changes and identifying appropriate administrative
205 policies to allow the expanded scope of practice. The rationale was based on benefits of direct
206 access and the regulatory authority permitting the requested practice (Appendix A). The
207 executive summary was used to provide a consistent and concise overview across the
208 administrative levels.

209 Initial discussions with the Director of PM&R and the Medical Director centered on the specific
210 language in the practice act permitting the requested practice change. After review of the Board
211 of Physical Therapy's opinion and the wording in the practice act allowing direct access, the
212 Director and Medical Director assisted the PT leadership team to develop a strategy to secure the
213 necessary additional approvals.

214 *(Insert figure 1 here)*

215 The next level in the chain of command was the Assistant Vice President of Ambulatory Care.
216 Based on the support of the Director of PM&R and the Medical Director, he offered his full
217 support and recommended that the approval of the Chief of Orthopedics be sought before
218 additional GUH administrative levels were approached. Involvement of the Department of
219 Orthopedics at this point, while not required in the GUH administrative approval process, was
220 considered a strategic decision as the expanded practice by the PTs could be interpreted as an
221 infringement on the domain of the orthopedic physician. In addition, securing support from the
222 Department of Orthopedics would facilitate discussions and counter objections from other
223 medical departments. The Chair of Orthopedics indicated his support without reservation
224 emphasizing the opinion that selection of a physical therapist as the first-contact provider was
225 primarily a consumer choice issue.

226 Continuing through the administrative approval levels, the Vice President of Medical Affairs and
227 Chair of the GUH Safety Committee approved the physical therapist expanded scope of practice
228 based on the endorsements received at the prior administrative levels. The enhanced consumer
229 choice was also cited as a positive factor in their support.

230 The last administrative approval was the Chief Operating Officer who is responsible for overall
231 hospital and clinic operations. He offered his support for the initiative stating it was an

232 innovative model for patient care that could ultimately lead to greater patient satisfaction. This
233 approval was essential before the final executive approval could be secured.
234 The full proposal with subsequent approvals was presented to the hospital’s Executive
235 Committee (EC), which acknowledged support with reservations on the fiscal impact and
236 reimbursement levels. The EC gave approval to implement a 3-month pilot study to assess
237 reimbursement trends and identify additional factors, if any, that would affect full
238 implementation. In addition, prior to implementation, necessary policy updates had to be
239 finalized and communicated to the various stakeholders both within and external to GUH. The
240 PT leadership team agreed to these conditions and marveled that, at no point along the
241 administrative approval pathway did they encounter opposition of any kind.

242

243 Policy Revisions

244 Following the last administrative approval, revisions to pertinent hospital policies and procedures
245 were initiated. Revisions to policies for non-physician independent providers, credentialing of
246 physical therapists, competencies necessary for the clinical privileges, and procedural revisions
247 to billing processes were required. Adding physical therapists to the list of non-physician
248 independent providers (such as physician assistants and dieticians) with “ordering privileges”
249 required revisions of GUH’s policy #109: Diagnostic and Therapeutic Orders. A new section
250 was added detailing the clinical privileges given to physical therapists. The language inserted
251 was concise and descriptive of the clinical privileges and referenced the regulatory authority
252 (Appendix B).

253

254 Credentialing

255 Credentialing is a process whereby an institution reviews the practice history of a provider
256 requesting clinical privileges. With employees, this can be a part of the initial hiring process and
257 background verification. As a non-physician independent provider, credentialing allows the
258 institution to develop a risk profile for the provider by verifying education, licensure, and any
259 prior liability actions. Third-party insurers use credentialing to determine if the provider is able
260 to be reimbursed for patient care. Credentialing policies establish re-evaluation periods to assure
261 continued competency to practice in the institution (Health Resources and Policy Administration
262 (HRSA), 2001). A full credentialing process as a non-physician provider can take 4-6 months to
263 complete at some institutions and should therefore be factored into the onboarding process.

264 Physical therapists at GUH underwent an initial verification of their practice credentials with the
265 assistance of administrative staff. Employment information including licensure history,
266 educational history, malpractice actions, National Provider Identifier (NPI), and specialty
267 certifications were used to establish eligibility for basic clinical privileges.

268 Advanced Practice Competencies

269 Specific competencies for the knowledge and skills for direct access and radiology referral
270 clinical privileges at GUH were identified by the leadership team (Appendix C). The existing
271 entry-level education of the physical therapists involved included bachelors, masters, and doctor
272 of physical therapy degrees. Some therapists indicated they preferred not to practice within the
273 expanded scope. Rather than do an individual review of each therapist's ability, the decision was
274 made to require those therapists wishing to expand their scope of practice to complete similar
275 activities to assure mastery of the competencies. The competency areas identified included
276 medical screening, radiology for physical therapists, time spent shadowing in radiology, and use

277 of clinical predication rules (Chou, et al., 2007; Bachman, Haberzeth, Steurer, ter Riet, 2004;
278 Bachmann, Kolb, Koller, Steurer, ter Riet, 2003; Stiell, Wells and Vandemheen, 2001; Seaberg,
279 Yealy, Lukens, Auble, Mathias, 1998; Stiell, Greenberg, McKnight, Nair et al, 1993). Use of the
280 American College of Radiology Appropriateness Criteria[®] (American College of Radiology,
281 2014) was included in the expected competency for radiology referral. These guidelines were
282 selected as the evidence-based clinical guidelines for radiology referral. To facilitate the initial
283 competency training, the physical therapy department hosted formal continuing education
284 courses for both medical screening and radiology.

285

286 Referral Process for Diagnostic Imaging Studies

287 Although administrative approval authorizing therapists to refer patients directly for diagnostic
288 imaging studies was secured relatively quickly, the process to actually implement the new
289 clinical privileges proved more challenging. The GUH electronic medical record and billing
290 systems used for radiology required separate registration of each provider in each system. The
291 integration of new providers into each system and linking to central billing required coordination
292 of several administrative units and required more time than initially anticipated. Follow-up and
293 consistent communication among all departments involved was required to keep the process
294 moving forward. This interprofessional collaboration was essential for success of the new policy.
295 A system of communication between radiologists and physical therapists was developed to
296 assure on-going interaction in a timely fashion. The system allowed the treating therapist to
297 share pertinent clinical information directly with the radiologist in order to facilitate referral and
298 determine which diagnostic test might be most appropriate in a particular case. This
299 collaborative approach maximizes the skill set of each clinician and minimizes ordering of

300 unnecessary tests. If abnormal findings were present, the radiologist and therapist could
301 collaborate on appropriate referral of the patient.

302

303 Billing Procedures

304 Ensuring all therapists were entered into the appropriate billing systems with individual National
305 Provider Identifier (NPI) numbers was the major billing procedure to be completed. The day to
306 day billing procedures for the therapists required no changes other than adding additional billing
307 code options.

308 At the time of implementation of the physical therapy initiative, GUH had several planned
309 technology updates in process integrating various systems in the hospital. The PT leadership
310 team was aware of these updates and assumed the task of assuring physical therapists would be
311 included as providers in the new systems.

312 IMPLEMENTATION

313 In January 2012, almost two years from starting the process, physical therapy direct access with
314 radiology referral privileges was implemented at Georgetown University Hospital. To our
315 knowledge, this was the first major civilian hospital system in the US to grant physical therapists
316 advanced practice status. Direct access with imaging privileges limited to plain film radiology
317 was reported by Boissonnault, Badke and Powers (2010) for the University of Wisconsin
318 Hospital and Clinics Authority with similar implementation challenges.

319 During the 3-month pilot study, the new clinical privileges were limited to three senior clinicians
320 to ensure the new policies and procedures allowed an acceptable level of operation.

321 Reimbursement trends were monitored to avoid denials prior to submitting a larger volume of
322 claims. Patients with Medicare coverage were not included since CMS regulations at the time of

323 implementation did not include physical therapists as non-physician providers. In March 2014,
324 the CMS regulations (Medicare Claims Processing Manual, Sections 30.6.1, 180.0) were
325 changed allowing Care Plan Oversight by physical therapists (evaluation with direct access but
326 treatment plans signed by a physician). During the initial 3-month pilot period, no issues were
327 identified and no adverse events occurred. At the completion of the pilot period, direct access
328 privileges were made available to any therapist who completed the credentialing process and met
329 the advanced practice competencies.

330 OUTCOMES

331 The expanded scope of practice was implemented in January 2012 and by October 2012, 66
332 patients had been seen in physical therapy through direct access. These episodes of patient care
333 represented less than 1% of the total patients seen at GUH. Patient diagnoses were similar to
334 those referred to physical therapy prior to implementation of direct access. Common diagnoses
335 included discogenic low back pain, medial tibial stress syndrome, metatarsal stress fracture, hip
336 osteoarthritis, and plantar fasciitis. Ten patients (15%) were referred for radiological studies. By
337 contrast, hospital records indicate roughly 30-40% of patients presenting to physical therapy
338 referred by physicians, received radiological studies prior to initiating physical therapy. Six
339 patients who accessed therapy services through traditional referral mechanisms were referred for
340 imaging by their physical therapist. Eight patients (11%) received advanced imaging studies
341 such as MRI. The American College of Radiology Appropriateness Criteria[®] (American College
342 of Radiology, 2014) was followed in all cases.

343 Physical therapists' decision-making and use of diagnostic imaging was monitored closely by the
344 senior clinicians. Before advanced imaging could be ordered, a consultation with a senior
345 clinician was required. In all cases, the use of imaging was justified to either rule in or rule out a

346 diagnosis that would ultimately change the course of treatment for that patient. An example of
347 an advanced imaging referral was for MRI to rule out a suspected posterior tibial tendon rupture
348 prior to seeking a surgical consultation. The rupture was ruled out with MRI and physical
349 therapy continued with the patient achieving a successful return to full function without surgical
350 intervention.

351

352 Reimbursement data:

353 Although concerns related to reimbursement have been cited by therapists as a significant barrier
354 to implementing direct access (Fritz, et al., 2008; Boissonnault, Badke, and Powers, 2010), no
355 problems with reimbursement to GUH were identified during the initial nine months. Twenty-
356 two separate insurance plans were billed for physical therapy direct access and/or radiology
357 services with no recorded denial of payment.

358

359 DISCUSSION

360 Expanded scope of practice for physical therapists has been a professional and regulatory
361 initiative in the United States for over four decades. While direct access is now authorized by
362 regulatory authority in all 50 states and the District of Columbia, implementation of direct access
363 is now largely dependent upon change at the institutional level. Professional initiatives may
364 provide guidelines for implementation; however, the individual physical therapist in the practice
365 setting must champion the administrative and policy changes to make it occur. This
366 administrative case study has described the efforts of physical therapists in a hospital system to
367 secure direct access and advanced practice through the clinical privilege process of the hospital.
368 Using a strategic planning process and working within the hospital system's existing

369 administrative structure, the granting of clinical privileges for physical therapist direct access and
370 radiological referral was accomplished without opposition from any stakeholder group. A full
371 credentialing process such as would be used on outside non-physician providers, was not needed
372 with the physical therapists already employed within the hospital. If limited prescriptive
373 authority had been sought, the credentialing process could have been more extensive. Although
374 the change took almost two years to implement, delays were due to administrative and
375 technology logistics which may be commonly encountered in a large hospital system
376 (Boissonnault, Badke and Powers, 2010).

377 The success of this initiative can be attributed to the physical therapy leadership and their
378 strategic plan to work within the existing organization's policies and procedures for independent
379 non-physician providers. The category of providers with specific clinical privileges exists in
380 most medical facilities accredited by the Joint Commission and therefore is available to other
381 PTs to secure an expanded scope of practice. An acknowledgement of the impact of the change
382 on the workflow of other departments allowed this initiative to be successfully implemented.
383 Working collaboratively with other health professionals and hospital administrative units was
384 necessary to establish regular inter-departmental communication, clear expectations, definitive
385 timelines, and ongoing problem solving and thus, to the eventual success of the expanded scope
386 of practice for physical therapists at GUH.

387 The anticipated challenges to implementation which included resistance from medical staff,
388 denials of claims, and lack of administrative support, never materialized in this case. The
389 existing clinical reputation of the physical therapy team, the professional relationships already
390 established between the physical therapy leadership team, and external departments along with
391 the development of advanced clinical competencies contributed heavily to the success of the

392 initiative. The lack of medical staff resistance in this case is counter to discussions of barriers to
393 implementation in large facilities. While no evidence could be found to support general medical
394 staff resistance in other implementations of direct access physical therapy, we feel our
395 experience should empower other physical therapists to approach medical staff in a similar
396 manner. Specific data on cost-effectiveness of care was not analyzed during the initial
397 implementation as the cost savings benefits of early access to physical therapy have been made
398 by several prior studies (Ojha, Snyder, & Davenport, 2014).

399

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475

476 Appendix A:

477 Executive Summary

478 Georgetown University Hospital

479 “Direct Access to Physical Therapy Services – Enhanced Patient Choice Initiative”

480 Introduction:

481 In January 2007, the Physical Therapy Practice Amendment Act (Bill 437) was signed
482 into law in the District of Columbia. This legislation significantly enhanced consumer choice by
483 allowing patients to see a physical therapist directly, without the requirement of a physician
484 referral if they so choose. Current Georgetown University Hospital (GUH) policies do not
485 reflect this updated practice act language. Patient satisfaction surveys consistently reflect
486 frustration over delays in accessing therapy services. Providing patients with the choice of
487 seeing a physical therapist without a physician referral eliminates inappropriate delays, reduces
488 overall cost per episode of care, greatly enhances patient satisfaction and reflects current physical
489 therapy practice standards.

490

491 A growing history:

492 Various forms of physical therapy direct access legislation have existed in other states for
493 decades. Currently, 48 states have adopted some form of direct access provision for patients.
494 The United States military has been using physical therapists as first contact providers for over
495 forty years. Military therapists function as orthopedic primary care providers and routinely order
496 diagnostic imaging studies, prescribe various forms of medication and make appropriate
497 specialty referrals for patients under their care. Kaiser Permanente Hospitals in California began
498 using physical therapists as primary care providers in the 1980’s. More recently, institutions

499 such as Johns Hopkins Hospital, the University of Wisconsin Health Centers and a growing
500 number of private orthopedic clinics have adopted direct access provisions for their patients.

501

502 Patient Satisfaction:

503 Delayed access to physical therapy services has been identified as a significant
504 contributor to reduced patient satisfaction at GUH. Providing direct access to physical therapists
505 without insisting upon a physician referral eliminates inappropriate delays, reduces co-pay costs
506 for patients and significantly empowers patient choice. A study conducted at Seattle-based
507 Virginia Mason Medical Center reported over 98% patient satisfaction scores when direct access
508 provisions were implemented for their patients.¹

509

510 Cost Containment:

511 Concerns that direct access provisions will result in overutilization of services by
512 physical therapists have been shown to be unfounded. A study published by Georgetown's Dr.
513 Jean Mitchell concluded that overall cost per episode of care was actually 50% less when
514 patients accessed physical therapy services directly compared with those referred by a physician.
515 Additionally, the overall number of treatment sessions given was significantly less for direct
516 access episodes (7.6 vs 12.2).²

517

518 Using health insurance claims data from Blue Cross-Blue Shield of Maryland, an expert
519 panel of physicians and physical therapists analyzed 8,920 episodes of care from 3,000

¹ Fuhrmans, Vanessa, 'A Novel Plan Helps Hospital Wean Itself Off Pricey Tests', *Wall Street Journal*, January 12th, 2007

² Mitchell, J de Lissovoy, G. 'A Comparison of Resource Use and Cost in Direct Access Versus Physician Referral Episodes of Physical Therapy', *Physical Therapy*; Jan 1997;77:10-17

520 individuals from 1989 through mid-1993. The authors concluded that, "Direct Access episodes
521 were shorter, encompassed fewer numbers of services, and were less costly than those classified
522 as physician referral episodes."³ More recently, an article published in the Wall Street Journal
523 confirmed that physical therapy costs were significantly reduced when patients were treated in
524 direct access situations as compared to treatment initiated by physician referral. By initiating
525 physical therapy treatment sooner, the development of secondary conditions is greatly reduced
526 thereby requiring less treatment overall.¹

527

528 Reimbursement:

529 According to the American Physical Therapy Association's Department of Payment
530 Policy, the largest insurance providers throughout the Northeast have all reimbursed for physical
531 therapy claims submitted without a physician referral. Ongoing efforts are being made by the
532 APTA to ensure insurance providers are aware of the cost benefit for therapy services provided
533 in direct access environments.

534

535 Patient safety:

536 A common rebuttal to the notion of physical therapists practicing in direct access roles
537 has been patient safety; particularly that therapists will overlook a serious condition that
538 necessitates a physician referral. Physical therapists are routinely trained in medical screening
539 and differential diagnosis procedures to determine underlying pathology that would necessitate a
540 physician referral. By law, physical therapists are currently mandated to refer patients to 'an
541 appropriate health care provider' when a condition falls outside of their scope of practice.

542

³ APTA online, retrieved on 7/1/10

543 Studies have shown the diagnostic accuracy of physical therapists when evaluating
544 musculoskeletal conditions to be equal to orthopedic surgeons and twice as accurate as non-
545 orthopedic physician providers.⁴ Furthermore, our leadership team has decided to personally
546 evaluate all department therapists who desire to function in direct access roles to ensure they
547 have received appropriate education and training in order to appropriately function in this
548 manner.

549
550 Finally, the national malpractice insurance provider for physical therapists, HPSO, has
551 reported no increase in the risk profile for physical therapists that practice in direct access roles.
552 Indeed, there has been no increase in malpractice claims whatsoever that can be attributed to
553 therapists functioning as first contact providers.

554
555 A team approach:

556 Elimination of the requirement for a physician order does not change the services provided
557 by the therapist nor does it undermine the relationship between the physician and the patient. On
558 the contrary, by functioning in an orthopedic primary care role for musculoskeletal injuries,
559 physical therapists are able to work more effectively and efficiently reducing excessive patient
560 visits and ensuring serious injuries are expedited to orthopedic surgeons. A close working
561 relationship between PTs and all other first contact providers enables the therapist to
562 autonomously manage nonsurgical musculoskeletal injuries thereby providing orthopedic
563 surgeons, primary care and emergency room physicians the opportunity to manage patients with
564 more complex surgical and medical problems.

565 _____
⁴ Moore J, Goss D, ‘Clinical Diagnostic Accuracy and Magnetic Resonance Imaging of Patients Referred by
Physical Therapists, Orthopedic Surgeons, and Nonorthopedic Providers’. *JOSPT*. Feb 2005;35:67-71

566 Appendix B:

567 Hospital Policy Updated Language

568 Hospital Policy 109

569 Section VII:

570 Outpatient Orders by Physical Therapists

571 *1. Per District of Columbia regulations (Direct Access Physical Therapy), out patients*
572 *may be seen by a physical therapist without the prescription of or referral by a licensed*
573 *physician, osteopath, dentist, or advanced practice nurse.*

574

575 *2. Only Physical Therapists who have received appropriate training in competencies*
576 *related to direct access and radiological referral may see patients who are self-*
577 *referred to the Georgetown University Hospital Physical Medicine and Rehabilitation*
578 *Department.*

579

580 *3. Per the District of Columbia, if an outpatient physical therapy patient fails to respond*
581 *to treatment within thirty days of the initial encounter, the physical therapist shall refer*
582 *the patient to an appropriate health care provider for assessment, medical diagnosis,*
583 *intervention or referral. Physical Therapists can directly refer outpatients to a*
584 *radiologist for imaging studies which may include but are not limited to x-rays,*
585 *magnetic resonance imaging, bone scans and Doppler ultrasound studies.*

586

587 Appendix C:

588 Clinical Competencies

589 Physical Therapist Direct Access

590 Competency Check List

591 To be completed by each therapist prior to functioning in a direct access role.

592 Therapist Name: _____

Competency:	Date completed:	Reviewed by:
Coursework in Medical Screening		
Coursework in Radiology for Physical Therapists		
Minimum 2 hours shadowing in radiology		
Review all direct access articles as outlined.		
Review 2-3 case vignettes with senior clinician		

593

594 Note: Each therapist functioning in a direct access role will have their first 10 charts reviewed by

595 an assigned senior clinician in order to encourage on-going discussion and ensure competence.

596