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.
BACKGROUND AND PURPOSE

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

Studies of advanced practice in physical therapy (APPT) have focused predominantly on musculoskeletal clinics and emergency departments (Desmeules, Toliopolos, Roy, Woodhouse, et al., 2013; Lebeck and Jogodka, 2009). Within the US and abroad professional association position statements and governmental regulatory commissions' reports have emphasized the inclusion of physical therapists as first-contact, autonomous, client-centered professionals whose services include traditional activities as well as advanced practice components including prescribing pharmaceuticals, ordering imaging and laboratory studies, or case management
(Health and Care Professions Council, 2012; Canadian Physiotherapy Association, 2012; Australian Physiotherapy Association, 2009; American Physical Therapy Association (APTA), 2002). While laws, regulations, and professional policies may allow advanced practice, administrative policies and individual professional competence may limit physical therapists from these privileges.

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

INTRODUCTION:

Direct access to physical therapy services has been defined as, “The ability of a health care consumer to freely visit a physical therapist without first securing referral from a physician” (Mitchell and de Lissovoy, 1997). The benefits of direct access have been documented in the literature and include: decreased cost per episode of care, improved short and long-term functional outcomes, reduced sick leave, decreased recurrence of back pain episodes, decreased prescription of muscle relaxants and narcotic analgesics, and significant improvement in patient satisfaction overall (Fritz, Cleland, Speckman, Brennan, et al., 2008; Fuhrmans, 2007; Jettte, Ardleigh, Chandler and McShea, 2006; Kelly and Bradway, 1997; Greathouse, Schreck, and
Primary barriers to implementation of direct access have been cited as local administrative policies and concerns over denials for reimbursement if a physician referral has not initiated care (McCallum and DiAngelis, 2012; APTA, 2010; Boissonnault, Badke, Powers, 2010; Crout, Tweedie and Miller, 1998).

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

The practice privilege approach to securing expanded scope of practice requires the clinician to function within established institutional policies and to collaborate in an inter-professional model
with other providers to manage conditions that may fall outside the clinician’s scope of practice. The clinical privilege model of care has proved effective for the US military for over forty years and serves as a model for advanced practice in physical therapy.

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

CASE DESCRIPTION:

Georgetown University Hospital (GUH) is a private, not-for-profit, 600-bed teaching and research hospital located in Washington D.C. GUH, a part of Medstar Health, is a regional healthcare system comprised of 9 hospitals and 20 other health-related businesses in the greater
Washington D.C. area. GUH’s organizational structure requires administrative approval at multiple levels in order to alter existing system or hospital policies. As a Joint Commission accredited facility, GUH has policies requiring independent health care providers with practice privileges to meet credentialing requirements and be granted specific clinical privileges within the approved scope of practice. When the effort to seek direct access at GUH began, physical therapists were not recognized as independent health care providers with clinical privileges to see patients under direct access or refer to other services. Physical therapists, as employees of the facility, were required to have physician referral prior to patient treatment.

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

Medical direction is provided by a physician board certified in neurology.

Regulatory Authority

District of Columbia Department of Health’s Board of Physical Therapy (BPT) licenses physical therapists employed at GUH to practice (DC Practice Act, 2011). The District of Columbia has legally allowed physical therapists to function as first contact providers since 2007. (First contact
providers are able to see patients for evaluation and treatment without a prior medical diagnosis. Direct access in some US jurisdictions requires a prior medical diagnosis but not referral to a physical therapist.) As is common in many practice acts, the District of Columbia Board of Physical Therapy requires therapists to refer patients to “an appropriate healthcare provider” when the patients’ condition falls outside the PT scope of practice. The responsibility to determine what conditions may fall outside a therapists’ scope of practice is dependent on the therapist's competency in assessing the specific presenting condition, as well as, various tests and measures which may include pharmacotherapeutics and imaging studies. While first contact provider and direct access are a recognized part of the physical therapists' scope of practice in the District of Columbia, referral for imaging studies was not specifically identified as within the scope of practice for physical therapists. Clinical privileges to request imaging studies are important in providing first contact provider care to an orthopedic patient population.

Expanding the Scope of Practice

GUH physical therapists began an initiative in late 2009 to implement an expanded scope of practice at the facility level which included clinical privileges for first contact and direct access as well as direct referral for imaging. Implementation of this expanded scope of practice required the leadership team to strategically plan for the regulatory, administrative, and provider competency changes that would ensure quality patient care. The PT management team began discussions on implementing the expanded scope of practice with the adult outpatient (OP) therapists. The majority of the OP team was in strong support, although several therapists were unaware of the updated practice act language. Additional concerns were expressed concerning medical staff support and reimbursement for services.
Clarification of the regulatory status of radiological referral was necessary before the advanced practice changes could be sought. The GUH physical therapists sought an opinion from the District of Columbia Board of Physical Therapy, specifically to clarify if physical therapists could refer patients for diagnostic imaging studies. The written opinion received was:

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

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

Administrative Approval:

GUH’s organizational structure requires policy changes to be approved by both administrative and medical leadership. With the legality of the initiative confirmed, administrative approval throughout the chain of command was then necessary. Approval at each administrative level above the PT department was required. The PT leadership team drafted an executive summary explaining the rationale for the recommended changes and identifying appropriate administrative policies to allow the expanded scope of practice. The rationale was based on benefits of direct access and the regulatory authority permitting the requested practice (Appendix A). The executive summary was used to provide a consistent and concise overview across the administrative levels.
Initial discussions with the Director of PM&R and the Medical Director centered on the specific language in the practice act permitting the requested practice change. After review of the Board of Physical Therapy's opinion and the wording in the practice act allowing direct access, the Director and Medical Director assisted the PT leadership team to develop a strategy to secure the necessary additional approvals.

(Insert figure 1 here)

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

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

The last administrative approval was the Chief Operating Officer who is responsible for overall hospital and clinic operations. He offered his support for the initiative stating it was an
innovative model for patient care that could ultimately lead to greater patient satisfaction. This approval was essential before the final executive approval could be secured. The full proposal with subsequent approvals was presented to the hospital’s Executive Committee (EC), which acknowledged support with reservations on the fiscal impact and reimbursement levels. The EC gave approval to implement a 3-month pilot study to assess reimbursement trends and identify additional factors, if any, that would affect full implementation. In addition, prior to implementation, necessary policy updates had to be finalized and communicated to the various stakeholders both within and external to GUH. The PT leadership team agreed to these conditions and marveled that, at no point along the administrative approval pathway did they encounter opposition of any kind.

Policy Revisions

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

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

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

**Advanced Practice Competencies**

Specific competencies for the knowledge and skills for direct access and radiology referral clinical privileges at GUH were identified by the leadership team (Appendix C). The existing entry-level education of the physical therapists involved included bachelors, masters, and doctor of physical therapy degrees. Some therapists indicated they preferred not to practice within the expanded scope. Rather than do an individual review of each therapist's ability, the decision was made to require those therapists wishing to expand their scope of practice to complete similar activities to assure mastery of the competencies. The competency areas identified included medical screening, radiology for physical therapists, time spent shadowing in radiology, and use
of clinical predication rules (Chou, et al., 2007; Bachman, Haberzeth, Steurer, ter Riet, 2004; Bachmann, Kolb, Koller, Steurer, ter Riet, 2003; Stiell, Wells and Vandemheen, 2001; Seaberg, Yealy, Lukens, Auble, Mathias, 1998; Stiell, Greenberg, McKnight, Nair et al, 1993). Use of the American College of Radiology Appropriateness Criteria® (American College of Radiology, 2014) was included in the expected competency for radiology referral. These guidelines were selected as the evidence-based clinical guidelines for radiology referral. To facilitate the initial competency training, the physical therapy department hosted formal continuing education courses for both medical screening and radiology.

Referral Process for Diagnostic Imaging Studies

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

Billing Procedures

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

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

IMPLEMENTATION

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

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

Reimbursement trends were monitored to avoid denials prior to submitting a larger volume of claims. Patients with Medicare coverage were not included since CMS regulations at the time of
implementation did not include physical therapists as non-physician providers. In March 2014, the CMS regulations (Medicare Claims Processing Manual, Sections 30.6.1, 180.0) were changed allowing Care Plan Oversight by physical therapists (evaluation with direct access but treatment plans signed by a physician). During the initial 3-month pilot period, no issues were identified and no adverse events occurred. At the completion of the pilot period, direct access privileges were made available to any therapist who completed the credentialing process and met the advanced practice competencies.

OUTCOMES

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

Physical therapists’ decision-making and use of diagnostic imaging was monitored closely by the senior clinicians. Before advanced imaging could be ordered, a consultation with a senior clinician was required. In all cases, the use of imaging was justified to either rule in or rule out a
diagnosis that would ultimately change the course of treatment for that patient. An example of
an advanced imaging referral was for MRI to rule out a suspected posterior tibial tendon rupture
prior to seeking a surgical consultation. The rupture was ruled out with MRI and physical
therapy continued with the patient achieving a successful return to full function without surgical
intervention.

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

DISCUSSION
Expanded scope of practice for physical therapists has been a professional and regulatory
initiative in the United States for over four decades. While direct access is now authorized by
regulatory authority in all 50 states and the District of Columbia, implementation of direct access
is now largely dependent upon change at the institutional level. Professional initiatives may
provide guidelines for implementation; however, the individual physical therapist in the practice
setting must champion the administrative and policy changes to make it occur. This
administrative case study has described the efforts of physical therapists in a hospital system to
secure direct access and advanced practice through the clinical privilege process of the hospital.
Using a strategic planning process and working within the hospital system's existing
administrative structure, the granting of clinical privileges for physical therapist direct access and radiological referral was accomplished without opposition from any stakeholder group. A full credentialing process such as would be used on outside non-physician providers, was not needed with the physical therapists already employed within the hospital. If limited prescriptive authority had been sought, the credentialing process could have been more extensive. Although the change took almost two years to implement, delays were due to administrative and technology logistics which may be commonly encountered in a large hospital system (Boissonnault, Badke and Powers, 2010).

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

The anticipated challenges to implementation which included resistance from medical staff, denials of claims, and lack of administrative support, never materialized in this case. The existing clinical reputation of the physical therapy team, the professional relationships already established between the physical therapy leadership team, and external departments along with the development of advanced clinical competencies contributed heavily to the success of the
initiative. The lack of medical staff resistance in this case is counter to discussions of barriers to implementation in large facilities. While no evidence could be found to support general medical staff resistance in other implementations of direct access physical therapy, we feel our experience should empower other physical therapists to approach medical staff in a similar manner. Specific data on cost-effectiveness of care was not analyzed during the initial implementation as the cost savings benefits of early access to physical therapy have been made by several prior studies (Ojha, Snyder, & Davenport, 2014).

REFERENCES:


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House of Delegates Policy. Alexandria, VA.


District of Columbia Physical Therapy Practice Act, Title 17, District of Columbia Municipal Regulations δ 6710 Lawful Practice, 2011.


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World Confederation of Physical Therapy 2011 WCPT Guideline for Physical Therapist Practice Specialization. London, UK: WCPT.
Appendix A:

Executive Summary

Georgetown University Hospital


Introduction:

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

A growing history:

Various forms of physical therapy direct access legislation have existed in other states for decades. Currently, 48 states have adopted some form of direct access provision for patients. The United States military has been using physical therapists as first contact providers for over forty years. Military therapists function as orthopedic primary care providers and routinely order diagnostic imaging studies, prescribe various forms of medication and make appropriate specialty referrals for patients under their care. Kaiser Permanente Hospitals in California began using physical therapists as primary care providers in the 1980’s. More recently, institutions
such as Johns Hopkins Hospital, the University of Wisconsin Health Centers and a growing number of private orthopedic clinics have adopted direct access provisions for their patients.

**Patient Satisfaction:**

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

**Cost Containment:**

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

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

individuals from 1989 through mid-1993. The authors concluded that, "Direct Access episodes were shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes."

More recently, an article published in the Wall Street Journal confirmed that physical therapy costs were significantly reduced when patients were treated in direct access situations as compared to treatment initiated by physician referral. By initiating physical therapy treatment sooner, the development of secondary conditions is greatly reduced thereby requiring less treatment overall.¹

Reimbursement:

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

Patient safety:

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

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³ APTA online, retrieved on 7/1/10
Studies have shown the diagnostic accuracy of physical therapists when evaluating musculoskeletal conditions to be equal to orthopedic surgeons and twice as accurate as non-orthopedic physician providers. Furthermore, our leadership team has decided to personally evaluate all department therapists who desire to function in direct access roles to ensure they have received appropriate education and training in order to appropriately function in this manner.

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

A team approach:

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

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Appendix B:

Hospital Policy Updated Language

Hospital Policy 109

Section VII:

Outpatient Orders by Physical Therapists

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

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

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

Physical Therapist Direct Access

Competency Check List

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

Therapist Name: ________________________________

<table>
<thead>
<tr>
<th>Competency:</th>
<th>Date completed:</th>
<th>Reviewed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coursework in Medical Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coursework in Radiology for Physical Therapists</td>
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<td></td>
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<tr>
<td>Minimum 2 hours shadowing in radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review all direct access articles as outlined.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review 2-3 case vignettes with senior clinician</td>
<td></td>
<td></td>
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</tbody>
</table>

Note: Each therapist functioning in a direct access role will have their first 10 charts reviewed by an assigned senior clinician in order to encourage on-going discussion and ensure competence.