State of Connecticut

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MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
REGULATIONS REVIEW COMMITTEE
PLANNING AND DEVELOPMENT COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE

From: Representative Vincent Candelora

Date: February 20, 2013

RE: H.B. 5376 An Act Prohibiting Physicians From Owning Businesses That Provide Physical Therapy Services.

I would like to thank the Honorable Co-Chairs Senator Terry Gerratana and Representative Susan Johnson, the Honorable Vice Chairs Senator Gayle Slossberg and Representative Philip Miller, and the Ranking Members Senator Jason Welch and Representative Prasad Srinivasan, and the entire membership of the Public Health Committee for their time this morning.

This proposal came from a constituent who made a compelling case for disallowing physicians from owning physical therapy services. I believe that Connecticut must examine this important issue of self-referral of physical therapy services by physicians. It's a conflict of interest, impacts consumer choice and may lead to adverse consequences for patients' health, as in the case of one of my constituents. See attached letter.

Under current law, physicians merely are required to disclose to patients their ownership or investment interest in a physical therapy practice before referring patients to that practice. This disclosure does not apply to ancillary services; and the disclosure may be conveyed by merely posting a sign in the physician's office. I believe that this currently structure does not provide the best practice for patients who are in a vulnerable condition to make fully informed decisions for their treatment options.

At the very least, if this bill is not advanced, I respectfully request that the committee consider referring this issue for a scope of practice review.

Vin Candelora
State Representative
86th Assembly District
Serving North Branford, Durham, Guilford and Wallingford

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MRS. ELEANOR ESTES
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7/6/12
CALLED TO CONFIRM
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7/13/12 JAMES ORLANDO (OLR)
DOING RESEARCH

June 30, 2012

Rep. Vincent Candelora
Legislative Office Building
Room 4200
Hartford, CT 06106

Dear Mr. Candelora,

I am writing to express my deep concern over the practice of allowing Physician Owned Physical Therapy Services (POPTS) in the State of Connecticut. And, after some preliminary research, I find that this type of practice raised concern in the states of Delaware, Missouri and South Carolina to the point where they have banned such ownership, thus forbidding PT's from sharing fees with a referral source. Other states with pending legislation on the subject currently include Arkansas, Arizona, Florida, Louisiana and Tennessee as listed by the American Academy of Orthepedia Surgeons, which indicates a growing concern across the country on the matter.

Allowing the continuance of POPTS in Connecticut certainly questions the presence of a conflict of interest , and in some instances, could even suggest a condition of collusion. I liken this to an association of educators having a primary financial interest in a text book publishing company or a group of real estate brokers owning a title company, neither of which would be in the best interests of their students or clients.

My concern in the POPTS operations comes from a direct experience with one and then treatment with an independent Physical Therapy and Sports Medicine service.

After a fall last winter in which I sustained a cracked pelvis and a broken left wrist I spent six weeks in rehab before being released. The rehab service was part of the facility where I was recovering and not an independently owned operation. My pelvis responded favorably to treatment but I continued to have serious problems with my wrist.

On my first follow-up visit to the orthopedic surgeon I was directed to continue rehab as an out patient at the POPTS with which he was affiliated. I WAS NOT TOLD THAT I HAD A CHOICE OF ANOTHER SERVICE , IF I SO CHOSE. Never having experienced physical therapy services in the past, I went to the facility and made an appointment with the staff Occupational Therapist. After several sessions with the OT, there was no improvement in the range of motion of my left arm or wrist and I had also developed contining pain in my left shoulder (I presumed from the treatment) which I mentioned to her.

On my next follow-up with the surgeon he felt that I now had a "frozen shoulder". He discontinued treatment for my wrist and ordered therapy for my shoulder. Seven 20 minute sessions later there was no improvement and I also had developed an extremely painful stiff neck (which again I presumed was from the treatments) and asked if something could be done

about it. I could not get a definitive answer and no treatment was forthcoming.

Back at the next follow-up with the surgeon I asked about my neck for which he had no answer. He also discontinued therapy and I was left in limbo. so to speak. Wrist wouldn't work, shoulder was still frozen and my neck was killing me.

In desperation I went to my family practitioner to see if he could help and he directed me to an independent physical therapy service . My original complaint to them was with my neck that was hampering my ability to turn my head , specifically to see rear oncoming traffic while driving.

I am pleased to say that they did a wonderful job returning the range of motion in my neck and they are now working on my shoulder and wrist with some success so far.

As an aside, while getting treatment with the POPTS I received several invoices which included charges listed as "Transfer from insurance to patient responsibility" with no explanation of the listed charges. It looked as though the amounts were the differences between what they charged and what Medicare and my supplementary insurance carrier paid. I returned copies of the invoices with the charges highlighted and asked for an explanation of same. It has been over two months since the request and I have had no answer nor have I had any further billings. It is my understanding that if Medicare is accepted the recipient agrees to the amounts that Medicare will pay and there will be no surcharges. I presume this is a separate situation but it should be looked into, and possibly by Mr. Blumenthal.

As the three states banning POPTS seemingly handled the problem through their state legislatures, I trust that you are the correct person for me to contact. If I am in error, I would appreciate your help in getting this to the proper individual(s) so that it can be considered.

Enclosed is a copy of a white paper issued in 2005 by the American Physical Therapy Association . To date, their position remains the same.

Also enclosed is a 2006 article from the American Academy of Orthepedic Surgeons' bulletin stating their thoughts on POPTS and to the best of my knowledge, their position remains the same today.

I would hope that proposed legislation concerning POPTS in Connecticut will be considered in the upcoming legislative session and, if I can be of any help in moving it along please do not hesitate to contact me.

Sincerely,

(Mrs.) Eleanor Estes

Encl.
cc: R. Blumenthal

Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

An American Physical Therapy Association White Paper

An American Physical Therapy Association White Paper

Position on Physician-Owned Physical Therapy Services (POPTS)

January 2005

Introduction

Physical therapy referral for profit describes a financial relationship in which a physician, podiatrist, or dentist refers a patient for physical therapy treatment and gains financially from the referral. A physician can achieve financial gains from referral by (a) having total or partial ownership of a physical therapy practice, (b) directly employing physical therapists, or (c) contracting with physical therapists. The most common form of referral for profit relationship in physical therapy is the physician-owned physical therapy service, known by the acronym "POPTS." The problem of physician ownership of physical therapy services was first identified by the physical therapy profession in the journal *Physical Therapy* in 1976.[1] While POPTS relationships were still limited in number in 1982, Charles Magistro, former APTA President, characterized POPTS as, "a cancer eating away at the ethical, moral and financial fiber of our profession."[2]

For many years, the American Physical Therapy Association (APTA) has opposed referral for profit and physician ownership of physical therapy services, taking the position that such arrangements pose an inherent conflict of interest impeding both the autonomous practice of the physical therapist and the fiduciary relationship between the therapist and patient. What became known as "the POPTS issue" was addressed by APTA's House of Delegates in 1983, 1985, and 1999, with APTA specifically opposing referral for profit arrangements between physicians and physical therapists.[3,4,5] The 2003 APTA House of Delegates once more resolved to develop state and federal legislative initiatives to achieve legal prohibition of POPTS.[6] However, in recent years, facing pressures of decreasing revenues and increased costs of malpractice insurance premiums, and aided by weakening of federal anti trust legislation, physicians have accelerated the addition of POPTS to their practice. APTA's push to achieve autonomous practice and direct access are in conflict with the medical profession's renewed push to subsume physical therapy as an ancillary service for financial gain.

At the center of the clash between these two opposing forces are two questions: First, should one profession be able to claim financial control over another? Second, what are the real and potential consequences of referral-for-profit relationships and, more specifically, POPTS? Physical therapists must be unified in their vision of physical therapy as a profession, accepting the rights and responsibilities that come with such a designation. Only when members of the profession view themselves as autonomous professionals will they present themselves to consumers and the medical community as such and curtail their own participation in referral-for-profit relationships, including POPTS. Within physical therapy practice and the broader medical community, there must be renewed examination of the ethical and legal consequences of referral-for-profit relationships, and a push to strengthen legislative and regulatory prohibitions of such relationships.

Evolution of Physical Therapy as an Autonomous Profession

A profession commonly is defined as an occupation, the practice of which influences human well being and requires mastery of a complex body of knowledge and specialized skills, requiring both formal education and practical experience.[7] Other elements of a profession include responsibility for keeping and advancing a body of knowledge; setting credible, useful standards; and self-governance.

In less than 80 years, the physical therapy profession evolved from a small group of women providing physical therapy to World War I soldiers and veterans to more than 110,000 men and women licensed as physical therapists and assistants, more than 66,000 of whom are represented by its professional organization, APTA. Physical therapists formed their first professional association in 1921. By the end of the 1940s, the APTA established its policy-making body, the House of Delegates.

As the Association further formalized its professional identity, the House of Delegates approved the Association's Code of Ethics in 1935, articulating principles for the ethical practice of physical therapy. The APTA Judicial Committee (now the Ethics and Judicial Committee) in 1981 adopted the Guide for Professional Conduct, which interprets the Code of Ethics. APTA further described the profession with the publication of *Guide to Physical Therapist Practice*,[8] representing a "framework for describing and implementing practice."[9]

In 1977, the Association assumed independent control for establishing educational standards through the Committee on Accreditation in Education (CAE), the forerunner of the Commission on Accreditation in Physical Therapy Education (CAPTE). As the profession expanded the scope of its services and the clients it served, physical therapy education programs also evolved, growing in depth and length from certificate programs to bachelor's and master's degrees. By 2007, 80 percent of all entry-level physical therapist education programs will be at the doctoral level, reflecting APTA's Vision 2020 Statement, "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy."[10]

Simultaneous with the profession's development of rigorous educational standards, a successful movement for licensure as autonomous practitioners was mounted. State licensure eventually replaced a "registry" that had been controlled by a physician board, culminating in physical therapist licensure in all 50 states.

For 25 years, the profession has demonstrated its commitment to establishing a unique and complex body of knowledge through the work of the Foundation for Physical Therapy. The Foundation has funded research that supports the development of evidence-based physical therapist practice, awarding more than $10 million in grants and scholarships to hundreds of researchers.

Physical Therapist: Professional Practice Owner or Employee?

Clearly, physical therapy meets the definitions of profession. As such, physical therapists should enjoy the legal protections accorded other professionals. In many states, professionals may not practice as agents of corporations except those formed as professional corporations,

in which all owners must be licensed to practice one profession. By adopting such laws states have prevented the inherent conflict that exists when one profession refers to another within the corporation for financial gain.

Historically, physical therapists were employed most frequently by hospitals, or other health care institutions. Ideally, as health care delivery evolves into other business models, physical therapists will seek business arrangements allowing control of the practice to be held by physical therapists, operating as independent or autonomous professionals. However, because physicians still largely control referrals for physical therapy, many physical therapists elect to become employees of physician professional corporations. A 2004 APTA survey on POPTS reported that more than 80 percent of the responding therapists encountered situations in which physicians retained patients within their own practices, rather than referring patients to other physical therapy providers.[11]

Real and Potential Effects of POPTS on Consumers

1) scope of practice
or
2) expand disclosure

Conflict of Interest. Once a physical therapist is employed by a physician or physician group, a conflict of interest exists, in which the best interests of the patient or client may be compromised for financial gain by the physician owner. Having a financial interest in other services to which a physician refers a client may cloud the physician's judgment as to the need for the referral, as well as the length of treatment required. Similarly, the physical therapist employed by a physician may face pressure to evaluate and treat all patients referred by the physician, without regard to the patient's needs. The consumer is likely unaware of any conflict of interest, assuming no conflict of interest exists when the service is provided within the physician's office. Physician associations have argued that self-referral to a physician-employed physical therapist is not a conflict of interest by labeling physical therapy as an "ancillary service,", one provided "incident to" physician practice. However, the suggestion that physical therapy is not a separate profession is clearly wrong.

Loss of Consumer Choice. In addition to inherent conflicts of interest that exist within POPTS, physician referral to services within his/her office, or to those with whom he/she may have a financial interest, limits the consumer's right to choose his/her physical therapist. The consumer may not recognize this loss of choice, as no other option is offered. Observation of the fiduciary responsibility between physician and patient is vital to preserving both consumer choice and the autonomous practice of the physical therapist.

Economic and Financial Harm. The harm done by POPTS is not merely a matter of principle or abstract ethics. Health policy researchers have provided data demonstrating specific harms from conflict of interest in physical therapy referrals. Studies have demonstrated that POPTS arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists. In a study examining costs and rates of use in the California Workers' Compensation system, Swedlow et al reported that physical therapy was initiated 2.3 times more often by the physicians in self-referral relationships than by those referring to independent practices.[12] In a subsequent symposium address by two of the study's authors, Johnson and Swedlow noted that physical therapy accounted for an estimated $575 million per year in California workers' compensation costs. Furthermore, they concluded that the

"phenomenon" of self-referral or POPTS "generates approximately $233 million per year in services delivered for economic rather than clinical reasons."[13]

In a study appearing in the *Journal of the American Medical Association*, Mitchell and Scott documented higher utilization rates and higher costs associated with services provided in POPTS (referred to as joint venture clinics) in the state of Florida.[14] The study revealed greater utilization of physical therapy services by the joint venture clinics, rendering on average about 50 percent more visits per year than their counterparts. It also concluded that visits per physical therapy patient were 39 percent higher in joint venture clinics.[14(p2057)] Joint venture clinics also generated almost 32 percent more net revenue per patient than their counterparts.

Rationale for Opposition to POPTS

Ethical Prohibitions. APTA and the American Medical Association actually agree on the fundamental principle of conflict of interest. The APTA Code of Ethics[15] and Guide for Professional Conduct [16] require that a physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services (Principle 7). The Guide contains specific prohibitions against placing one's own financial interest above the welfare of individuals under his/her care (7.1.B), as well as overutilization of services (7.1.D). The Guide also requires physical therapists to disclose to patients/clients if the referring physician derives compensation from the provision of physical therapy (7.3). The AMA, like APTA, rejects the conflict of interest inherent in referral for profit. The AMA Council on Ethics and Judicial Affairs (CEJA) has said that, "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients,"[17] and that, "physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility."[18] The latter statement could be interpreted to prohibit referral to physical therapy practices in which a physician has an investment interest when he/she does not directly provide care or services to the referred patient.

Legal and Regulatory Prohibitions. Real and potential conflicts of interest among physicians with financial interests in entities to which they refer were recognized by members of Congress in the 1980s. The correlation between financial ties and increased utilization was the impetus for Congress to enact the "Stark I" law in 1989,[19] preventing Medicare from paying for clinical laboratory services if the referring physician had a financial interest in the facility. In 1993, Congress enacted the "Stark II" law, which expanded the list of services to which the laws applies to include physical therapy services[20] Specifically, the law states that if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services (including physical therapy services) under the Medicare program, unless an exception applies. After the law was enacted, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) issued final regulations implementing the law on January 4, 2001.[21] Unfortunately, bowing to physician interests, the agency wrote rules that enable physicians to structure their practices in order to furnish physical therapy in their offices (so-called "incident to" services discussed previously) without violating the law.

Conclusion

Recognizing the incongruity of POPTS and APTA's Vision 2020 that embraces the autonomous practice of doctorally prepared professionals, the inherent conflicts of interest existing within POPTS, the loss of the patient/client's right to choice of provider, and the increased cost to society identified resulting from POPTS, the American Physical Therapy Association reaffirms its decades-long position of opposition to physician-owned physical therapy services. APTA supports legislative and regulatory measures at the state and federal levels to ban physician ownership of physical therapy services. These efforts include sponsoring efforts to strengthen state practice acts to prohibit POPTS—and gaining direct access to Medicare patients.

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[1] Hiltz DL. Hiring of physical therapists. [Letter to the editor]. *Phys Ther.*1976;56(9):1061.
[2] Magistro CM. Physician-Physical Therapist Financial Arrangements. Read at Combined Sections Meeting of the American Physical Therapy Association, San Diego, Calif. February 14-17, 1982.
[3] Report of the House of Delegates session. *Phys Ther.* 1983;63(11):1810.
[4] '99 House issues strong statements. *PT—Magazine of Physical Therapy.* 1999;7(9):82.
[5] *Progress Report.* 1985;14(7):5.
[6] Opposition to physician ownership of physical therapy services reaffirmed. *PT—Magazine of Physical Therapy.* 2003;11(9):64.
[7] The Online Ethics Center for Engineering and Science at Case Western Reserve University. Available at http://onlineethics.org/glossary.html. Accessed July 23, 2004.
[8] Guide to Physical Therapist Practice. Phys Ther. 1997;77:1163-1650.
[9] Rothstein J. On the second edition of the guide, *Phys Ther.* 2001;81(1):6-8.
[10] APTA House of Delegates. APTA Vision Sentence for Physical Therapy 2020 and APTA Vision Statement for Physical Therapy 2020 (HOD 06-00-24-35). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/GOALS_AND_MISSION/HOD_06002435. Accessed January 7, 2005.
[11] Unpublished results of APTA member survey on the impact of physician ownership of physical therapy services. September 2004.
[12] Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self-referral by physicians. *NEJM.*1992;327:1502-1506.
[13] Johnson G, Swedlow A. Medical referral-for-profit in California workers' compensation. Unpublished addendum to the authors' 1992 article, based on course notes from their presentation of findings at a physical therapy symposium. January 1992.
[14] Mitchell JM, Scott E. Physician ownership of physical therapy services. *JAMA.* 1992;268:2055-2059.
[15] APTA House of Delegates. Code of Ethics (HOD 06-00-12-23). American Physical Therapy Association. 2000. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_I/ETHICS/HOD_06001223. Accessed January 7, 2005.
[16] APTA Ethics and Judicial Committee. Guide for Professional Conduct. American Physical Therapy Association. 2001. Available at http://www.apta.org/governance/HOD/policies/HoDPolicies/Section_4/GUIDEFORPROCONDUCT. Accessed January 7, 2005.
[17] AMA Council on Ethics and Judicial Affairs. Current Opinions. American Medical Association. Available at http://www.ama_assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[18] American Medical Association Council on Ethics and Judicial Affairs. Current Opinions E-8.03 Conflicts of Interest: Guidelines and E08.02 Conflicts of Interest: Health Facility Ownership by a physician. Available at http://www.ama-assn.org/ama/pub/category/2498.html. Accessed November 23, 2003.
[19] Omnibus Budget Reconciliation Act of 1989, Pub L No. 101-329, Section 6204.
[20] Omnibus Budget Reconciliation Act of 1993, Pub L No. 103-66, Section 13562.
[21] 66 *FR* 855 (Jan 4, 2001) (codified at 42 CFR Parts 411 and 424).

Ancillary services under attack

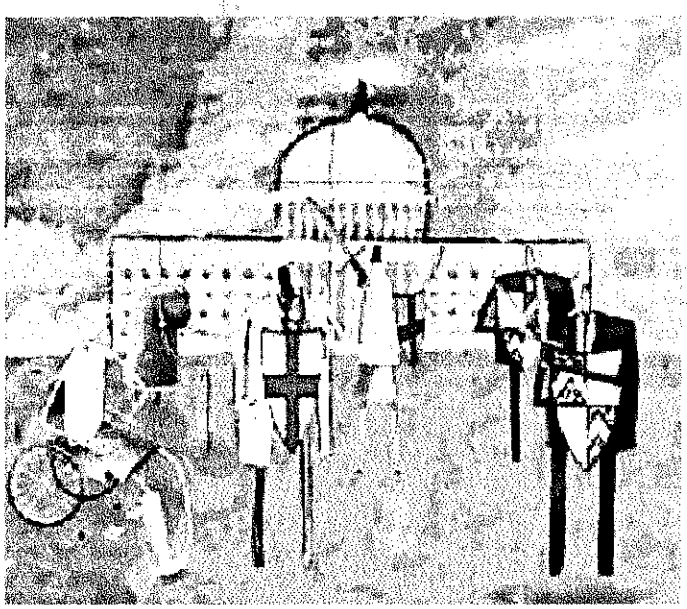
It's getting harder for orthopaedists to offer office-based physical therapy and imaging services.

By Robert C. Fine, JD, CAE

Ancillary services—such as office-based physical therapy and imaging services—are essential parts of orthopaedic practice. Most orthopaedists provide them because they're good medical care and because they're a convenience to patients who would otherwise have to travel elsewhere for such services.

In recent years, office-based physical therapy and imaging services have come under attack by outsiders attempting to interfere with orthopaedic practice. This time, however, the usual suspects are not government and private payers. Instead, the culprits are physical therapy and radiology associations bent on increasing the number of patients their members see and expanding their scope of practice.

This issue of the Bulletin examines the current situation facing orthopaedists who offer ancillary services, with a focus on physician-owed physical therapy and imaging services, particularly magnetic resonance imaging (MRI).



Physician-owned physical therapy services

Physical therapists (PTs) may work in freestanding physical therapy centers, hospitals or medical practices. Most are independent contractors or employees; some have their own physical therapy facilities. Physician-owned physical therapy services (POPTS) refers to physicians that employ PTs.

The exact number of orthopaedic practices that employ PTs is unknown. A 2004 survey of AAOS leaders, including members of the Board of Councilors (BOC), found that about 25 percent of respondents employed PTs. Although this survey does not statistically reflect the entire AAOS membership, it does show that a sizable number of orthopaedists employ PTs in their practices.

POPTS provide a number of benefits for patients, physicians and physical therapists. Patients may find it more convenient to have physical therapy at their orthopaedists' offices than to travel somewhere else. Patients may also feel more comfortable knowing that their PT and their doctor are working together at the same location.

"Our patients think it's great to have these services in one location and not have to travel," says Russell A. Hudgens, MD, a BOC member from Mobile, Ala. "We have very flexible hours, so a patient can schedule an early-morning appointment with the physical therapist before work or stop on the way home. I don't know of

any other facility in our area that offers that kind of convenience."

POPTS give some orthopaedists the chance to interact more quickly with PTs than they might if the PTs are off-site. POPTS also allow orthopaedists to offer their patients a wider range of services in the same location.

"It's a great benefit," says BOC member Paul N. Krop, MD, of Virginia Beach, Va. "Having the physical therapist right there is very helpful in fine-tuning postoperative exercises to respond to the patient's condition. There's better communication when the therapist is in the office and can simply walk over to the doctor to ask a question or make a suggestion."

"The constant exposure of having a physical therapist on staff is great," agrees BOC Chair-elect Matthew S. Shapiro, MD, of Eugene, Ore. "We have a terrific relationship with our two part-time physical therapists on staff and will often see patients together."

Finally, POPTS give PTs more employment opportunities. Although many PTs like working in hospitals or PT facilities, others would prefer to be part of a medical practice.

"Our employed PTs like providing their service in a medical office," says Dr. Krop. "They're paid adequately, and consider their compensation comparable to what they could make on their own."

Eliminating POPTS reduces the number of workplace choices for PTs, and could lead to increased unemployment within the profession.

Naturally, not all orthopaedic practices will employ PTs nor will patients go only to orthopaedists with PTs on staff. Many orthopaedists have good working relationships with PTs who are self- or hospital-employed. Patients can receive excellent care from independent as well as employed PTs. But those orthopaedists and PTs who want to work together in an employment arrangement for their own benefit and the benefit of their patients should be free to do so.

The opposing argument

Those opposed to POPTS argue that a conflict of interest exists between physicians and PTs who have an employment relationship. This argument seems to assume that physicians, as employers, are not interested in what's best for their patients but only how they can make more money by providing in-office physical therapy services. A corollary assumption is that these physicians are forcing PTs to provide unnecessary or inappropriate services.

This argument not only condemns physicians who offer in-office physical therapy services, but also challenges the integrity of the PTs who work in medical practices. It implies that office-based PTs are so afraid of their physician-employers, they are willing to provide bad patient care. But according to AAOS members, that's not at all true.

"Our PTs enjoy a great deal of autonomy," responds Dr. Hudgens. "We work together to develop treatment

guidelines. Within those established guidelines, they're free to do what's most effective for the patient."

"Our PTs uniformly understand the subtle demands that complex knee and shoulder reconstruction requires. For the roughly half of our patients who visit them, I repeatedly see superior rehabilitation outcomes and surgical results," says BOC member John D. Kelly IV, MD, of Philadelphia.

If, in fact, physicians who employ PTs are interfering with physical therapy services to make more money, wouldn't the same hold true for PTs who employ other PTs in their own facilities? Those opposing POPTS, however, have not expressed concerns about this issue.

Another argument against POPTS focuses on the professional relationship between physicians and physical therapists. This argument says that physicians do not recognize their employed PTs as colleagues nor do they see physical therapy as a distinct health care profession.

On the contrary, most orthopaedists and other physicians who employ PTs give great weight to their judgment and are well aware of their unique knowledge and skills. "Our staff PTs are phenomenally talented," says Dr. Shapiro. "The constant interaction between physician and therapist gives both of us a better understanding of each other's roles and the patient's needs. I also think the interaction gives our PTs a higher level of sophistication about musculoskeletal conditions."

Legislative and legal challenges to POPTS

State physical therapy practice acts govern the conduct of PTs. Self-referral laws govern the kinds of ancillary services that physicians can have in their practices. Both types of laws can affect where PTs work.

Missouri's self-referral law prohibits physicians from sending patients to physical therapy practices in which they have an ownership interest. This effectively bans physicians from employing PTs.

Most other states do not have such language in their self-referral laws, although these laws can always be amended if someone can persuade the state legislatures to do so. However, changing current laws is usually harder than reinterpreting existing ones.

Therefore, a more promising opportunity to challenge POPTS involves reinterpreting existing state physical therapy practice acts. This is because several states have practice acts that contain unclear language about whether or not a PT can accept patients from a physician-employer. In these situations, the opponents of POPTS use the following strategy:

1. Find a state attorney general who is likely to interpret the physical therapy practice act as prohibiting PTs from accepting patients from their physician-employers.

2. Approach a sympathetic public official to ask the state attorney general to issue an opinion on the physical therapy practice act.

3. The state attorney general issues an opinion stating that the physical therapy practice act prevents PTs from accepting patients from their physician-employers.

4. The state's physical therapy board then adopts the state attorney general's opinion as policy or as its own new interpretation of the physical therapy practice act.

5. The new policy or new interpretation of the physical therapy practice act has the practical effect of preventing PTs from being employed by physicians.

In 2002, the Delaware attorney general concluded that PTs could be disciplined under that state's physical therapy practice act for accepting patients from their physician-employers. Although a "grandfather clause" exempted PTs who were already employed by physicians, the PTs hired by physicians after the legislation passed can be sanctioned for treating patients from their physician-employers.

A similar situation occurred in South Carolina in 2004—but without the "grandfather" clause. All PTs working for physicians were given 90 days to comply with the new interpretation of the practice act.

Other states that may be targeted include Arkansas, Arizona, Florida, Louisiana and Tennessee, all of which have physical therapy practice acts that forbid PTs from sharing fees with a referral source. This language possibly could be interpreted as preventing PTs from accepting patients from physician-employers.

Other states still face the possibility that their legislatures will change their physical therapy practice acts or self-referral laws to essentially bar PTs from being employed by medical practices.

AAOS and state society responses

The AAOS has been working with state orthopaedic societies to counter these efforts.

In South Carolina, for example, the South Carolina Orthopaedic Association and a coalition of other concerned parties responded to the attorney general's position by suing the state's Board of Physical Therapy Examiners to stop them from revoking the licenses of PTs who work for physicians.

The suit challenged the new interpretation of the state's physical therapy practice act. Although the coalition lost the suit at the trial level, it is now being appealed. The AAOS joined the appeal late last year with an amicus curiae brief supporting the coalition's position. A decision is expected by the end of summer.

The AAOS is working with other state orthopaedic societies to counter any legislative attempts to limit POPTS. In addition, the AAOS has set aside $200,000 for state societies to use in dealing with this and other pressing state health policy issues.

Direct access

Some physical therapists would like to have direct access to patients. It's easy to see why.

Direct access gives PTs a broader patient base and greater independence in deciding what kind and how much therapy to give patients.

It's also easy to see why direct access is bad for patients.

A patient who goes to a physical therapist without a physician referral also goes without a medical diagnosis. Although a PT is an important part of the musculoskeletal care team, he or she is not qualified to make medical diagnoses. And without a medical diagnosis, the PT cannot be sure that the therapy being provided is appropriate for the patient. If it's not, the patient can delay getting the right treatment while the undiagnosed condition may be worsening.

Direct access at the state level

Although some physical therapy groups claim that most states allow direct access of PTs to patients, only two—Iowa and Montana—have unlimited direct access laws.

Six states do not allow direct access at all; eight allow PTs to evaluate, but not treat, patients without a physician referral; 15 allow direct access with limitations, such as a 30-day time limit on treatment, after which the PT must get a physician referral; and 19 have laws that are silent on the issue of direct access.

In many of these states, the battle is on for unlimited direct access of PTs to patients. And state orthopaedic societies are working hard with the AAOS to counter those efforts.

Direct access in the Medicare program

In 2003, Congress directed one of its advisory bodies, the Medicare Payment Advisory Commission (MedPAC), to study the feasibility of allowing Medicare patients direct access to PTs.

In its report to Congress in December 2004, MedPAC recommended that PTs not be given direct access to patients. According to the MedPAC report:

Beneficiaries often have multiple medical conditions and physicians can consider their broad medical needs ... Without these physician requirements, the medical appropriateness of starting or continuing physical therapy services would be more uncertain. [1]

MedPAC's findings and recommendation seem to have laid to rest, for now, any further attempts to give PTs direct access to Medicare patients.

POPTS and direct access

The connection between the issues of direct access and physician-owned physical therapy services is clear. They are linked by the desire by some to expand PTs' scope of practice and independence from physicians. As long as any PTs are employed by physicians, it's harder to argue that PTs should be completely independent from physicians. Unfortunately, these efforts may come at the expense of the musculoskeletal care team approach and, most important, the musculoskeletal patient.

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