

Physical Therapy Prescriptions: Is "Eval & Treat" Enough?

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Lisa Soldat, MD, MS, FAAFP

Dr. Soldat recently retired after 25 years of medical practice. From 2008 until her retirement, she was a faculty physician at the University of Iowa in Iowa City and its affiliated residencies. She also served as an adjunct clinical assistant professor in family medicine at the University of Iowa Carver College of Medicine, Iowa City, and an adjunct assistant professor of family medicine at Des Moines University College of Osteopathic Medicine, Iowa. Since 2012, Dr. Soldat has teamed up with other Iowa family physicians to help develop family medicine as a specialty in Indonesia, and she defines "retirement" as the opportunity to promote family medicine in new ways, both locally and globally. She continues to have an active interest in women's health, obstetric ultrasound, international medicine, and wilderness medicine. Dr. Soldat believes that family medicine's most critical challenge is training physicians to have a broad skillset (including obstetric skills) so they can meet the needs of patients in any community. Such training is particularly important for physicians who choose to practice in rural settings worldwide.



Learning Objectives

1. Use evidence-based recommendations to order physical therapy prescriptions, based on clinical evaluation of the presenting health condition.
2. Use evidence-based recommendations to order physical therapy prescriptions as an adjunct to a multimodal program in the treatment of chronic musculoskeletal conditions.
3. Foster patient adherence to physical therapy prescriptions by engaging patients in creating collaborative care plans, and by having a care coordination plan that tracks referral completion, correspondence and patient feedback.



Audience Engagement System



- 48 yo accountant
- 54 yo house painter
- 35 yo weekend warrior
- 70 yo home gardener



All complain of intermittent low back pain

Physical therapy seems like a great idea, right?

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How about these patients?

- Patient in the hospital burn unit
- Nursing home patient with pressure ulcer
- Infant with congenital torticollis
- Older adult with vertigo
- Obese teen needing pre-participation sports clearance

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Physical Therapists Are Specialists

PT "Prescription" = "PT Referral"

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Physical Therapy Education: *History*

- Certification Program (1917)
 - Polio epidemics (1894, 1916) and WW I
 - "Reconstruction aide" 3 month training
- Baccalaureate degree (1930-40's)
 - WWII and polio
 - 12-24 months
 - Required 2 years of nursing or physical education
- Masters of Physical Therapy (2000)

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Doctor of Physical Therapy (DPT)

- 3-4 year post baccalaureate program
- "Transitional DPT"
 - Bachelor or Master of Physical Therapy
 - 1-3 years
- **January 1, 2016: DPT is the required degree offered by all accredited programs**

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Specialization after DPT

- 8 Areas:
- Cardiovascular and Pulmonary, Clinical Electrophysiology, Geriatrics, Neurology, Orthopedics, Pediatrics, Sports and Women's Health

Clinical residency
- ≥ 1500 hours in 9-36 months

Clinical fellowship
- ≥ 1000 hours in 6-36 months

Certified clinical specialization
- Voluntary and unrestricted process, coordinated by ABPTS

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Learning Objective #1

Use evidence-based recommendations to order physical therapy prescriptions, based on clinical evaluation of the presenting health condition

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Components of the Physical Therapy Prescription

PATIENT NAME: _____ DATE: _____	
DIAGNOSIS: _____ ICD CODE: _____	
SUBJECT: _____	
<input type="checkbox"/> EVALUATE AND TREAT	
<input type="checkbox"/> MANUAL THERAPIES <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Soft tissue mobilization <input type="checkbox"/> Manual traction <input type="checkbox"/> Trigger point release	<input type="checkbox"/> ADDITIONAL SERVICES <input type="checkbox"/> Shock wave therapy <input type="checkbox"/> Reflex to work/ergonomics <input type="checkbox"/> Reflex to training <input type="checkbox"/> Reflex to driving <input type="checkbox"/> Reflex to recreation <input type="checkbox"/> Reflex to home <input type="checkbox"/> Reflex to school <input type="checkbox"/> Reflex to work/ergonomics
<input type="checkbox"/> THERAPEUTIC EXERCISES <input type="checkbox"/> Core stability <input type="checkbox"/> Strength/stability/gait <input type="checkbox"/> Lower body functional program <input type="checkbox"/> Upper body functional program <input type="checkbox"/> Manual stabilization <input type="checkbox"/> Neuromuscular re-education	<input type="checkbox"/> MODALITIES <input type="checkbox"/> Heat/cold <input type="checkbox"/> Ultrasound <input type="checkbox"/> TENS <input type="checkbox"/> Hydrotherapy <input type="checkbox"/> Phototherapy <input type="checkbox"/> Electrostimulation <input type="checkbox"/> Dry needling
<input type="checkbox"/> TREATMENT PLAN <input type="checkbox"/> Therapist direction <input type="checkbox"/> Duration of therapy: _____ <input type="checkbox"/> Frequency of therapy: _____ <input type="checkbox"/> 1 2 3 4 5 days/week	<input type="checkbox"/> SPECIAL INSTRUCTIONS <input type="checkbox"/> PRECAUTIONS
PHYSICIAN SIGNATURE: _____ DATE: _____	

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Case # 1: Making the Diagnosis

- Patient with medial left knee pain
- Mild-moderate OA on X-ray
- Physician diagnosis: left knee OA
- Referred to PT
- PT determines the chief problem is pes anserine bursitis

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AES: True or False

For proper reimbursement, the physician must provide the physical therapist with a detailed diagnosis

1. True
2. False

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PT Prescription: Coding

- Specific diagnostic coding by ordering physician not required
- PTs will submit coding/billing based on their own evaluation

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DIAGNOSIS: _____ ICD CODE: _____	
SUBJECT: _____	
<input type="checkbox"/> EVALUATE AND TREAT	
<input type="checkbox"/> MANUAL THERAPIES <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Soft tissue mobilization <input type="checkbox"/> Manual traction <input type="checkbox"/> Trigger point release	<input type="checkbox"/> ADDITIONAL SERVICES <input type="checkbox"/> Shock wave therapy <input type="checkbox"/> Reflex to work/ergonomics <input type="checkbox"/> Reflex to training <input type="checkbox"/> Reflex to driving <input type="checkbox"/> Reflex to recreation <input type="checkbox"/> Reflex to home <input type="checkbox"/> Reflex to school <input type="checkbox"/> Reflex to work/ergonomics
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PHYSICIAN SIGNATURE: _____ DATE: _____	

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Frequency and Duration of Treatment

- Communication between physician and PT essential in evaluation, treatment and response to therapy
- Frequency and duration may be best established by the treating provider, ie, the physical therapist

PATIENT NAME: _____ DATE: _____	
DIAGNOSIS: _____ ICD CODE: _____	
SUBJECT: _____	
<input type="checkbox"/> EVALUATE AND TREAT	
<input type="checkbox"/> MANUAL THERAPIES <input type="checkbox"/> Joint Mobilization <input type="checkbox"/> Soft tissue mobilization <input type="checkbox"/> Manual traction <input type="checkbox"/> Trigger point release	<input type="checkbox"/> ADDITIONAL SERVICES <input type="checkbox"/> Shock wave therapy <input type="checkbox"/> Reflex to work/ergonomics <input type="checkbox"/> Reflex to training <input type="checkbox"/> Reflex to driving <input type="checkbox"/> Reflex to recreation <input type="checkbox"/> Reflex to home <input type="checkbox"/> Reflex to school <input type="checkbox"/> Reflex to work/ergonomics
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PHYSICIAN SIGNATURE: _____ DATE: _____	

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Should the physician request specific PT modalities or protocols?

Considerations:

- Training/experience of the physician
- Training/experience of the physical therapist
- The condition being treated
- Evidence supporting the modality or protocol being requested

The image shows a physical therapy form with several sections: 'EVALUATE AND TREAT', 'THERAPEUTIC EXERCISE', 'THERAPEUTIC PLAN', 'SPECIAL INSTRUCTIONS', and 'PRECAUTIONS'. A blue circle is drawn around the 'THERAPEUTIC EXERCISE' section, which lists various modalities and exercises.

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The image shows a physical therapy form with sections for 'NORM Restrictions and Expectations' and 'Should Therapy Restrictions'. It includes a table for tracking patient progress through different phases of treatment, with columns for 'Week' and 'Days'.

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THERAPY ORDER: Physical Therapy Status post Revision right naviculocuneiform fusion with autologous bone graft from the right iliac crest, Removal of broken hardware from the right naviculocuneiform joint, on 7/24/2015.
 Exercise/Treatment: AROM, stretching, AAROM, PROM, strengthening/PRE and modalities per patient response.
 Intrinsic strengthening
 Frequency: # of Visits: 10-12. Please send progress report.

or

“Evaluate and Treat”

Case # 2

- You see your patient back after 3 months of physical therapy for lateral epicondylitis. You review the PT’s report, which lists several modalities that have been used along with therapeutic exercises.
- The patient asks what you think about some of the modalities being used, because he isn’t sure he’s noticed any improvement and he wants to stop PT.

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Common PT Modalities

- Therapeutic ultrasound
- Low-level laser therapy
- Transcutaneous electrical nerve stimulation (TENS)
- Pulsed electromagnetic field therapy (PEMF)
- Phonophoresis
- Iontophoresis

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Therapeutic Ultrasound

- High frequency sound waves
 - Warms superficial tissues (continuous ultrasound)
 - May accelerate tissue healing (pulsed ultrasound)
- Optimal dose, frequency and treatment interval not known
- Little evidence of clinical effectiveness for pain, musculoskeletal injuries or soft tissue healing.
 - May provide short-term pain relief

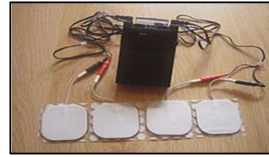
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Low-Level Laser Therapy

- Mechanism of action unclear
 - Photochemical reaction at the cellular level
 - Not thermal effect
- Indications
 - Minor muscle pain (FDA approved)
 - Carpal tunnel (FDA approved)
 - Tendonitis
 - Arthritis (OA and RA)
- Unclear benefit

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Transcutaneous Electrical Nerve Stimulation (TENS)



One meta-analysis showed positive effects for chronic musculoskeletal pain

Some RCTs have shown positive effects for acute, emergent, and postoperative pain conditions

Uncertain benefit for individual pain conditions, such as low back pain

- (new OTC Tens unit approved by FDA for LBP in 2016)

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Pulsed Electromagnetic Field Therapy (PEMF)



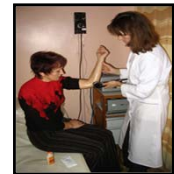
(Circa 1990's)

- Insufficient evidence
- May offer short-term relief
 - Rotator cuff
 - Osteoarthritis
- Adjunct to other therapy
- FDA approval:
 - delayed-union bone fractures, failed joint fusions, and congenital pseudarthroses

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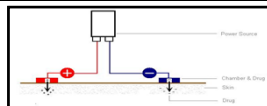
Phonophoresis

- Therapeutic ultrasound delivers drugs to deeper tissues
 - Steroids, NSAIDs
 - 10% concentration
 - 1-2 watts/cm²
- Indications:
 - Inflammatory conditions
 - Mixed evidence of benefit



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Iontophoresis



- Electric current delivers ionically charged substances to deeper tissues
 - Dexamethasone 0.4% solution
- Indications
 - Calcific tendinopathy, arthritis, bursitis
- Mixed evidence of benefit
- Adjunct to other therapies

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Other Available Modalities

- Elastic therapeutic tape
- Dry needling

Many health providers can utilize these modalities

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Elastic Therapeutic Tape (aka Kinesiotape)

Function:

- Lifts the skin and improves blood/lymph flow

Purposes:

- Structural support
- Reduce inflammation
- Stimulation/inhibition of muscle activity



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Proper Tape Tension

- Proper tape tension used for different purposes
 - Light tape tension (0-15%)
 - To improve lymph flow
 - Moderate tape tension (25%)
 - For fascia, circulatory, stimulating and inhibiting muscle activities
 - Moderate-high tape tension (50-100%)
 - For ligament/tendon treatment
- Commercial brands have varying tension
 - Tape color does not correlate with different tensions
 - More mechanically similar with light tension
- \$10-20/box

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Does Kinesiotaping work?

Prescriber's Letter
Nov 2015: Kinesiology
Tape

Possible benefit

- Strength
- Force sense error
- Active range of motion in the injured area

No evidence to support

- Pain
- Proprioception
- Muscle activity



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Case # 3

- Patient has been diagnosed with peroneal tendonitis, tender to palpation along the length of the tendon, distal > proximal.
- The physical therapist recommends dry needling of identified trigger points in the adjacent muscles.

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Trigger Points

- Highly localized, irritable areas in palpable taut bands of skeletal muscle
- Associated with nearly every musculoskeletal pain condition
 - Primary source of pain in 30-85% of patients presenting with pain in primary care

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Dry Needling

- Aka
 - intramuscular stimulation
 - Westernized acupuncture
 - Medical acupuncture
- Exact mechanism of action unclear
- Introduction of solid needle, no drug
 - Trigger point and connective tissue stimulation



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Dry Needling: What's the evidence?

- Systematic review:
 - Short term pain relief
 - No short- or long-term improvement in
 - function, quality of life, depression, range of motion or strength

Morihisa, R, Eskew, J, McNamara, A, Young, J. Trigger Points in the Lower Quarter: A Systematic Review. *International Journal of Sports Physical Therapy*, 11(1): Feb 2016

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Why use any modality if there is limited evidence of benefit for (at best) short term relief?

- Short-term pain relief
 - helps break the inflammation/pain/dysfunction cycle
 - provides an opportunity to focus on long-term improvement

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Objective #1: Summary

- The PT prescription should focus on optimal communication between the physician and the physical therapist
- Many PT modalities are available, but not all have good evidence for long-term benefit; studies of multimodal benefit are lacking

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Learning Objective #2

Use evidence-based recommendations to order physical therapy prescriptions as an adjunct to a multimodal program in the treatment of chronic musculoskeletal conditions

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Physical Therapy Model of Care

Typically:
exercise + modalities + patient education

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Case # 4

- 45 year old runner
- Increased workouts 3 months ago as part of marathon training program
- Achilles tendon pain x 2 months
- Diagnosis? Tendinitis or tendinopathy?

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Tendinopathy

- Chronic tendon injury (tendinosis)
 - pain > 6 weeks
 - Overuse injuries
 - Occur in tissues with poor blood supply
 - Collagen separation and degeneration
- **Not histologically inflammatory**
 - Modalities designed to decrease inflammation may still have some benefit

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Achilles Tendinopathy

- Short term
 - Ice
 - Steroid injections
 - Ultrasound
 - Iontophoresis
 - Massage/stretching
- Long term
 - Eccentric strengthening programs
 - 60-90% improvement in pain and function

Childress MA, Beutler A. Management of Chronic Tendon Injuries. *Am Fam Physician* 2013; Apr 1;87(7):486-490

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AES: Case # 5

- G3P2 at 24 weeks gestation
 - Complains of pubic symphysis and bilateral hip pain: "feels like my hips are going to pop out when I climb stairs"
- Q: What are you likely to recommend as the first step?
- A. Write her a prescription for a maternity belt
B. Refer her to physical therapy
C. Provide her with home exercises
D. Tell her: "It's just the normal aches and pains of pregnancy"

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About 50% of pregnant women experience musculoskeletal pain

- Common causes
 - Ligament laxity
 - Abdominal and pelvic floor muscle weakness
 - SI joint dysfunction
 - Postural changes, poor body mechanics
 - Diastasis recti

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Pelvic Floor Disorders

- Pelvic floor dysfunction
 - Myofascial pelvic pain
 - Pudendal nerve entrapment
 - Pubic symphysis pain
 - Vulvodynia/vulvar vestibulitis
 - Pelvic organ prolapse
- Sexual dysfunction
 - Dyspareunia
 - Vaginismus
- Bladder/bowel dysfunction
 - Incontinence
 - Chronic non-bacterial prostatitis
 - Interstitial cystitis
 - Constipation
- Pregnancy and post-partum care

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PT for Chronic Pelvic Pain: does it work?

- Small, well-designed studies show some benefit
- Systematic review: insufficient evidence
- Biofeedback might be better than electrotherapy or massage

Consider PT if pelvic floor tenderness is present

Speer LM, Mushkbar S, Erbele T. Chronic Pelvic Pain in Women. *Am Fam Physician* 2016;93(5):380-387

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Pelvic Floor Evaluation

- Vaginal and/or rectal exam to assess neuromuscular function
 - Primary and secondary drivers of dysfunction
 - Muscles, nerves, joints and soft tissue
 - Myofascial trigger points
- Posture, gait
- Bowel/bladder habits

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Myofascial Pelvic Pain: Treatment

- Therapeutic exercises
 - Stretching, core strengthening
- Manual therapy
 - Connective tissue restrictions, trigger point release, neuromuscular reeducation
- Biofeedback
- Home exercises/patient education

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PT for Chronic Prostatitis/Chronic Pelvic Pain Syndrome

Physical therapy can include:

- Transrectal manual pelvic floor tender point release
- Pelvic floor muscle exercises
- Hip ROM exercises, stretching, postural correction and paradoxical relaxation training
- Biofeedback-assisted techniques for pelvic floor reeducation

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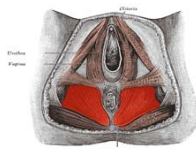
Case # 6: Dyspareunia

- 31 year old healthy woman
- Chief complaint: dyspareunia since childbirth 2 years ago
- No bowel or bladder dysfunction
- No history of physical abuse

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Dyspareunia

- Etiology: Pain/overactivity of the levator ani muscles
- Goal: treat overactivity of levator ani muscles
 - Manual therapy
 - Biofeedback
 - Therapeutic exercises
 - Vaginal dilators
 - Desensitize vaginal tissue
 - Promote muscle relaxation



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Urinary Incontinence: Treatment Options

- Pelvic floor Muscle Training (PFMT)
 - Kegel exercises
 - Recommended for all types of incontinence
 - May require supervised pelvic floor therapy
 - Supplemental modalities
 - Vaginal weighted cones
 - Biofeedback
- Bladder training

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Urinary Incontinence: General Recommendations

- Stress incontinence
 - PFMT (first line)
 - Adjunctive biofeedback might be beneficial
- Mixed stress/urge Incontinence
 - PFMT + bladder training
- Urge incontinence
 - Bladder training + PFMT

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Case # 7

- 25 yo active female, plays frisbee golf
- BMI of 34
- Diagnosis: plantar fasciitis
- Multiple modalities have provided partial short-term relief

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AES: True or False

Should the physical therapist offer nutrition counseling as part of the plan of care?

1. True
2. False

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PT Scope of Practice: Nutrition

- Weight management
 - Reduce joint load
 - Manage chronic pain
- Performance nutrition
 - Training, performance and post-performance recovery
 - Weight management while training or injured
 - Nutritional deficiencies impacting performance

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Objective # 2: Summary

- Consider physical therapy for more than musculoskeletal conditions...
 - Areas of PT specialization:
 - » Cardiopulmonary, Geriatrics, Neurology, Orthopedics, Pediatrics, Sports and Women's Health

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Learning Objective #3

Foster patient adherence to physical therapy prescriptions by engaging patients in creating collaborative care plans, and by having a care coordination plan that tracks referral completion, correspondence and patient feedback

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You determine your patient would benefit from PT.

How do you proceed with obtaining an appointment?

What obstacles to access are present?

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What Obstacles Exist from the Patient Perspective?

"I can't go to PT because . . . "

- *I can't take time off from work*
- *I don't see the benefit*
- *PT makes my pain worse*
- *I can't afford it*
- *My insurance doesn't cover it*

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What Obstacles Exist from the Physician Perspective?

- Is a prescription necessary?
 - If so, how much information is needed?
- What is the wait time for an appointment?
 - Are there enough physical therapists in my area?
- Which physical therapist is best for my patient?

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Are there enough physical therapists to meet demand in your area?

- 34% expected job growth expected from 2014 to 2024
 - Average job growth (all occupations) = 7%
- Increased demand expected from
 - Aging baby boomers
 - Mobility issues from chronic conditions

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Case # 8

- 68 year old healthy male
- "Back went out" while shoveling heavy snow yesterday
- Now complains of severe pain shooting down his left leg, can't stand up straight
- Wants an X-ray to make sure "nothing is wrong"

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AES: What are you most likely to do first?

1. Order an imaging test now
2. Prescribe NSAIDs and/or muscle relaxants and follow up in 2 weeks
3. Home back exercises + meds and follow up in 2 weeks
4. Refer to PT within 72 hours

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Low Back Pain

- If advanced imaging performed first:
 - One-year LBP-related health care charges were about \$4700 higher
 - ↑ odds of surgery, injections, specialist and ER visits within the year

Fritz, J, Brennan GP and Hunter SJ. Physical Therapy or Advanced Imaging as First Management Strategy Following a New Consultation for Low Back Pain in Primary Care: Associations with Future Health Care Utilization and Charges. Health Services Research: Health Services Research December 2015

- Why? “the labeling effect”

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Labeling Effect

- Imaging “labels” or “medicalizes” the problem regardless of the test results
 - No longer uncomplicated or nonspecific
 - Motivates additional care-seeking by both patients or providers
- Breaking an expectation by denying imaging can be unacceptable to patients and/or providers

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Early physical therapy is a credible alternative to imaging

- “Early” referral:
 - Within 1-2 weeks of initial event
 - Should it be even sooner?
- Encourages earlier return to normal activities
- May be helpful for physicians who lack time or experience in supervising exercise therapy

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Recent-Onset Low Back Pain in Adults ≥ 65 years old

Fritz JM, Magel JS, McFadden M, et al. Early physical therapy vs usual care in patients with recent-onset low back pain: a randomized clinical trial. JAMA 2015;314(14):1459-1467

- Imaging within 6 weeks of injury
 - resulted in NO improved outcomes at one year
 - Increased overall health care costs by almost 30%
- Very early referral to PT (within 72 hours) compared to routine care
 - Is minimally effective (or less) for decreasing disability or improving quality of life.

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Case # 9

- 50 yo female, s/p midfoot fusion and non-weight bearing cast for 3 months
- PT not ordered by orthopedic surgeon
- Patient wants physical therapy to improve mobility and function

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Who makes the PT appointment?

- Provider's office
 - Orthopedic surgeon?
 - Primary care physician?
- PT clinic after referral received?
- Patient?

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Direct Access to PT

- Patient can initiate contact with PT
- Physician referral not required
 - Unless required by insurance
- Advantages:
 - Decreased wait times for access to care
 - Reduced costs to consumers
 - Decreased overall healthcare costs

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Direct Access Provisions Differ by State

- Limited access (6 states)
 - Treatment restricted to patients with a previous medical diagnosis or subject of a previous physician referral
- Patient access with provisions (26 states, DC)
 - Time or visit limit, or referral requirement for a specific treatment intervention such as needle EMG or spinal manipulation.

http://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Direct_Access/DirectAccessbyState.pdf

18 States have Unrestricted Access

- Alaska
- Arizona
- Colorado
- Hawaii
- Idaho
- Iowa
- Kentucky
- Maryland
- Massachusetts
- Montana
- Nebraska
- Nevada
- North Dakota
- Oregon
- South Dakota
- Utah
- Vermont

http://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Direct_Access/DirectAccessbyState.pdf

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The Evidence for Direct Access

- Statistically significant findings:
 - Patient satisfaction (B)
 - Improved outcomes (C)
 - Cost-effective (B)
 - Fewer visits (PT and non-PT)
 - Less imaging
 - Fewer medications/injections
 - No evidence of harm (C)
- Patients still maintained contact with other medical providers

Ojha HA, Snyder RS, Davernport TE. Direct Access Compared With Referred Physical Therapy Episodes of Care: A Systematic Review. *Phys Ther J* 2014; 94: 14-30.

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Plan of Care remains the same with or without a physician referral

- Goals and expected outcomes
- Predicted level of improvement
- Specific interventions to be used
- Proposed duration and frequency of therapy
- Anticipated discharge plans, follow up and/or referral

What about communication with patient's physician?

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PT and PCMH

- Physical therapy is not specifically named in the Affordable Care Act
- Medical homes can contract with physical therapists
 - to provide services to their patients
 - to assist in meeting stated quality metrics

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PT within PCMH

- Advantages
 - Improved access for patients
 - Improved triage for entry into health care
 - Improved communication between all providers
 - Shared education and training opportunities
- Goals: optimize communication, follow up and patient satisfaction

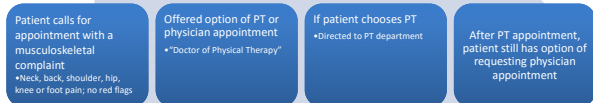
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Incorporating PT into PCMH

- Possible options:
 1. Embed PT into existing clinics
 2. Provide access to PT within designated time period (eg 72 hours)
 - Acute care/walk-in appointments
 - Same day appointments following physician visit
 3. Coordinate subsequent physician and PT appointments

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One Strategy for Direct PT Access Within PCMH



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Practice Recommendations

1. Physical therapy prescriptions can be simple or detailed depending on training of the physician and PT's scope of practice
2. Consider PT referral earlier and for a wider variety of conditions
3. Physical therapy can be successfully incorporated into a PCMH; especially if direct access care is available.

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Questions

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Contact information

lisasoldat@earthlink.net

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Billing & Coding

When services performed in conjunction with:

Office Visit 992xx

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aafp.org/fmx-internal

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